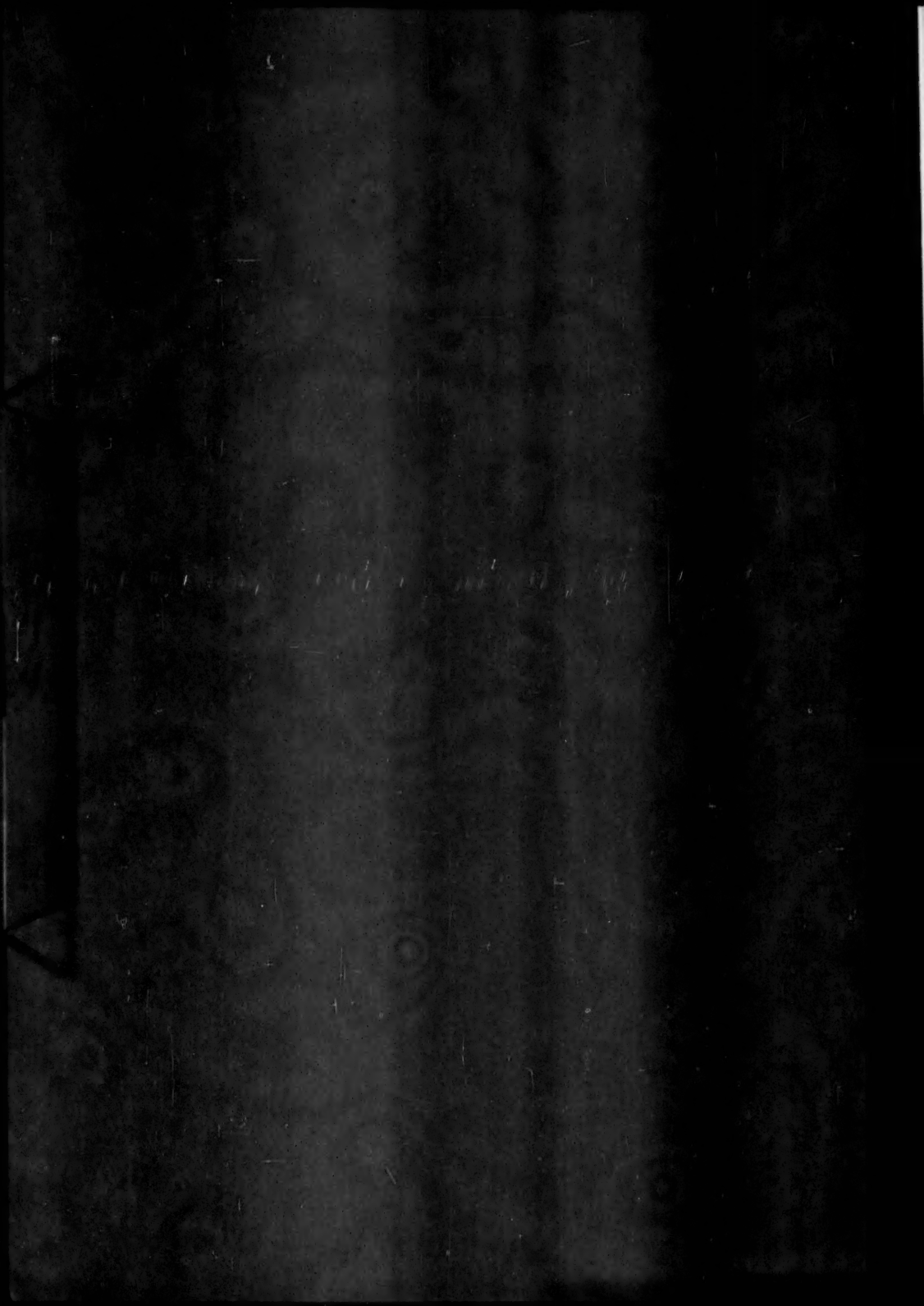

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BEHAVIORAL CONCEPTS AND PSYCHOTHERAPY*

BY D. EWEN CAMERON, M. D.

The way things look to us is the way in which we will try to deal with them. If the road looks to us icy enough to be dangerous, we will drive accordingly; if we believe that pre-marital virginity is to be esteemed, we will try to maintain it.

This is the tritest of truisms, but a truism carried into a new field will often freshen up amazingly. So, transferred into the realm of human behavior, the proposition now takes this shape: that the way we think about human behavior will determine how we try to manage it.

This report records some exploration of the extent to which various of our beliefs about human nature hinder or facilitate psychotherapy. Does, for instance, a strong belief that the individual can be relieved of a sense of guilt only through atonement, or a concept of the individual as being capable of almost unlimited exertions through the use of his will power, affect the way in which individuals react to psychotherapy?

Such studies are a segment of the immense revision of our cultural concepts which is being carried on all around the world. With quick communication, large numbers of people have seen for themselves, and still larger numbers have learned the simple fact that in a great range of societies across the earth people have carried on their lives on the basis of very different ideas of how human behavior works, on the basis of quite different sets of values. And they live out their lives with reasonable success.

Hence the belief in absolute values in human behavior is beginning to crumble. We have come to realize that what we have accepted as the facts of human psychology and sociology, as well as our philosophic and religious values, are simply our ways of conceptualizing the data of human behavior, and that they are by no means necessarily the most effective ways.

So you see men everywhere at work on this immense and difficult task of reviewing and, where necessary, destroying concepts, many of which are of great antiquity, deeply rooted in our customs, the source of power to particular groups and hence to be dealt with only at some risk by the pioneers in this field. Questions

*Delivered to: Bronx Society of Neurology and Psychiatry, New York, May 19, 1949.

simple and profound are being asked. Questions are being placed in anger, hot with long resentment, or cool in scientific appraisal. Should the punishment fit the crime; are men at work primarily motivated by economics; are we entirely free agents, and if not, is it useful to conceive of us as responsible in the sense of the law; is there an absolute "good," and, indeed, is the moral system the most effective way of dealing with human nature?

It is with some relief that we turn from this vast, generations-long rewriting of these prodigious problems to the small sector which we have outlined, namely, the relationship between belief and the response to psychotherapy.

Turning, however, we must not lose sight of the fact that this section is part of the whole, and that what we learn here will be joined to all that hurrying knowledge which is being so rapidly carried into the building of the future.

These investigations now to be reported took origin in a series of observations which were first published in an article entitled "Frontiers of Social Psychiatry" (1946). They consisted primarily in the contrasting of the types of breakdown admitted to psychiatric departments in general hospitals in two areas, which, while lying close to each other, showed certain differences in their dominant cultural patterns. These areas were Albany and Montreal.

At that time, it was observed that in the Albany area there was a predominance of admissions of those who had broken down in the senium and of patients suffering from mood disorders; while in the Montreal area* there was a predominance of rather involved psychoneurotic breakdowns.

It was considered that the excess of admissions of those in the senium in the Albany area over those admitted in the Montreal area reflected the greater extent to which the "caring" functions of the home were preserved in the Montreal cultural pattern. The different emphasis upon mood and psychoneurotic breakdown was seen as an indication of the extent to which success and failure were preoccupations in the Albany area, and the extent to which moralism, with its attendant conflicts over customs and conventions, was dominant in the Montreal cultural pattern.

*Admissions to the Allan Memorial Institute of Psychiatry, Montreal.

The impression was gained that the local mores determined not only the nature of the hospital admissions, but also, at least in some measure, the kind of breakdown under stress—in the Albany area, frustration over failure to attain the culturally-esteemed success resulted in depression or reactive excitement; in the Montreal area, conflict over the exacting mores resulted in anxiety, guilt, repression and psychosomatic manifestions.

A relation between cultural pattern and breakdown has of course been reported from a variety of sources. Labarre (1948) refers to the fact that Kraepelin described both the phenomenon of "running amok" in Malayan males and a psychosis among Malayan females described as "latah." He refers also to "arctic hysteria," "beserker rage," and the dancing manias of the seventeenth century, none of which exists in current North American culture. Moreover, though the authorities have never been willing to permit publication, several army medical services have reported correlations between the subcultural groups to which their recruits belonged and the types of breakdown which they showed, either at induction or subsequently.

Clearly, then, there is some evidence that the kind of breakdown shown by a person is related, to a certain degree, to the kind of culture in which that person grew up. From here one passes over to ask the very natural question as to whether recovery from breakdown is also affected by the cultural pattern.

When the writer started out to examine this problem, it was decided to take the patient's concept of human behavior—how it works, what motivates or curbs it, how the individual is related to his society—as that aspect of the cultural pattern which is of most significance in the present matter.

From among the therapies, the indiviudal's response to psychotherapy was chosen as being the most likely to indicate the effects of his concepts of behavior upon his ability to recover, since, as is well known, this form of therapy commonly requires that we change concepts and patterns of behavior alike.

During the period which has intervened since the study of the Albany and Montreal admissions, the area from which the Allan Memorial Institute of Psychiatry in Montreal receives patients has been greatly expanded. They come from all across Canada, from northern New England and New York State, and even from the West Indies. Under such circumstances, it has been possible to

examine patients brought up in a considerable variety of subcultural groups within American society, and hence there has been an opportunity to investigate the possible effects of a wide range of concepts upon the individual's response to psychotherapy.

For the sake of clarity, the observations here are confined to persons suffering from psychoneurotic breakdowns.

During the last five years, approximately 1,200 psychoneurotic patients have been treated at the Allan Memorial Institute. Of these, 400 have been dealt with directly in individual psychotherapy. The examination and treatment of the rest has been supervised. From this work, a most considerable body of material upon the relationship between the individual's concept of human behavior and his response to psychotherapy has been accumulated. This will be described in terms of the way in which the individual conceptualizes certain basic aspects of his behavior.

I. Concept of Power

One of the surest things that men everywhere know of themselves is that they act—they buy from each other, they work, join armies or bridge clubs; they restrain each other or themselves; they build, destroy and march to the edges of their world.

Whence comes the power that moves them to these ends? Each culture has its concept of this power—a concept so basic, so inlaid in the structure of the society, that it is rarely remarked. In a similar way, gravity is a universal phenomenon that no architect explicitly takes into his calculations, but likewise no architect builds save in anticipation that gravity will be operating.

Thus, the idea of power as necessary to carry on human affairs is so general and the way in which it is conceived as derived is so widespread within a given culture that it is not commonly stated in any discussion of behavior within that society.

Nevertheless, men do differ most considerably, from one cultural group to another, as to how they conceive of power operating in their affairs. To bring this out, one may point to the fact that the Ojibway Indians see the animals as being their guardians, and seek to derive power from supernatural sources by propitiating these animal guardians, who in turn are thought to be in direct contact with these supernatural powers. The Zunis, on the other hand, see man and nature as being in a correlative partnership—if each side plays his part, all will go well. They attempt to bring

this about by carrying out elaborate rituals and ceremonies. The Plains Indians, especially those who practise the peyote cult, attempt to gain power from visions. The Dobus, in northwestern Melanesia, conceive of great power as residing in incantations and spells, and will attempt by any trick to learn their neighbor's procedures and then turn them against him.

Our society, in contrast, is in the process of transition with respect to its concepts of how power is derived.

In the Middle Ages, and for some centuries thereafter, power to run human affairs was seen as drawn exclusively from supernatural sources. This was true both of power for good and for evil. Phrases such as "God is all-powerful," or, "Being in league with the Devil," had a meaning that was entirely literal. During this period, moralistic evaluation of behavior was universal. Behavior was labeled, and as will be seen, these quality labels themselves in the course of time came to be conceived of as sources of power. Men were good or bad, lazy or courageous, and, being so labeled, could anticipate that others would react to them in terms of these designations. And most important, it was the general expectation that men designated as bad would do evil because that was the way in which they were set to behave—no further inquiry into their natures or motivations was deemed necessary.

Here one may see that a set of happenings—namely, the dealings of a man with others—was converted into a set of qualities. In a word, there was a conversion of the dynamic into the static, of the "how" into the "what." With the slow but gathering progress of science, this dynamic-static shift has gradually been reversed. This was true first of non-living and particularly non-human happenings, but more lately this has been extended to interpersonal happenings. We have come to see power as derived from the happenings themselves and not from any supernatural sources. Hence we are interested—in general, and most particularly in our psychiatric histories—in evaluating the sort of behavior which the individual has shown previously, as a means of understanding the kind of behavior which he is likely to show in the future. We do not assess supernatural forces as likely etiological factors in drawing up our diagnosis, and the supplication through prayer of the possible curative powers of transcendental agencies receives no discussion in our texts on psychotherapy.

This great shift in our concept of the origin of power—a shift from outside the happenings to within them—while expressing itself most clearly in science, has already shown itself in a number of other fields. It is an important dynamic of humanism and of the rapidly spreading secularism. While among scientifically-trained men this concept has made considerable headway, the public from which our patients are derived has not yet made such an extensive transition. While it is true that only a limited number see power in human affairs as directly derived from supernatural forces, a most considerable majority see power as residing in qualities rather than in happenings. Goodness and badness are very real, and whole intricate patterns of behavior are designated by such adjectives as sinful, lazy, cowardly, without any further attempt being made to understand and manipulate such behavior.

As illustrative of this, we may point to those individuals who see hatred of the mother as evil, make no effort to understand how it comes about, and hence can only attempt to deal with it in terms of punishment.

It is difficult to describe in any satisfyingly exact terms the immense confusion of this period of transition. Patients come to psychotherapy with concepts of human behavior as being directly dependent upon supernatural power, though here one must think that the majority holding these concepts do not seek psychiatric assistance but attempt to find a solution on strictly moralistic terms. Others come with derived secondary concepts such as, "You can't change human nature," or concepts of the inborn and static nature of certain characteristics—"I just am no good; I guess I was born this way." Still others have made partial adaptations to the viewpoint of power as being imminent in here-and-now happenings rather than as being derived from supernatural sources or from qualities.

An interesting illustration is provided by a patient who came for psychotherapy considerably disturbed by a serious physical handicap consisting of a paralysis in one leg and almost intolerable pain in the distribution of his right sciatic nerve. He was devoutly religious and believed, in an almost literal sense, that his deity could do anything he wanted to. When he was a little boy in Sunday school he had received a picture of Christ as being gentle, passive and turning the other cheek. When the patient was five or six years old, his father died, and it is noteworthy that when in his

years of puberty he came to attend Bible class, he met what he describes as a real teacher and got what he felt to be a true picture of Christ as a normal boy who grew up into a vigorous man. The patient then replaced his original concept (which he said was an erroneous one) of a mealy-mouthed individual, with this new picture of a strong, affirmative, uncompromising figure. At the same time, he found a satisfactory solution for his own vigorous tendency to rely upon himself and his concept of supernaturally derived power in the idea that his God intended people to help themselves to the utmost of the abilities which He had given them. Hence the patient was freed from the fatalistic passivity of those who see all power as coming directly from supernatural forces.

We may conclude this consideration of the concept of power by saying that of the three concepts commonly found in our culture: (a) that of power coming directly from supernatural forces; (b) that of power being derived from qualities of behavior; (c) that of power as imminent in the behavioral happenings themselves; the first two constitute impediments to psychotherapy, and in particular to non-directive types of psychotherapy. In some instances, individuals holding concepts (a) and (b) are able to assimilate concept (c)—namely, that of power as imminent in behavioral happenings—and apply it as long as it does not come into direct conflict with highly-charged beliefs derived from either of the other two categories.

In a number of cases, however, we have found that a directive form of therapy is more suited to the passive-authoritarian personality structure of such individuals, but we must conclude that in all probability the majority of those who have been strongly indoctrinated with concepts of power as being directly received from supernatural forces or from derived (moralistic) qualities do not seek psychotherapy at all—they attempt solutions in moral terms and through somatic remedies.

II. Concept of Relationship of Individual to Society

A second concept of human behavior which the writer has found to be of significance in assessing probable response to psychotherapy is that of the relationship of the individual to his society. Among the writer's patients, there were none holding completely totalitarian views; and, hence, it is not possible to report on the effects of such concepts upon the course of psychotherapy. A

number of patients however, have been encountered, who see themselves as having a fixed relationship to their society, and a number who see themselves as having a highly mobile relationship to their society.

The viewpoints of the first were expressed in such phrases as "Having a place in society," "Knowing one's place," "Keeping one's place," "Getting the respect due to one's place," and "Giving the proper respect to persons on account of their place."

These views are clearly those to be found in a relatively static and highly-stratified society. At least in the western world, this type of society is breaking down, and, hence, those individuals who hold such views are quite commonly much threatened by the course of events. It cannot be said that the maintenance of such a concept of the relationship of the individual to his society offers much of an impediment to psychotherapy, save insofar as the individual might find it necessary to maintain a constellation of beliefs supporting this idea, and as far as these beliefs themselves constitute impediments. For instance, a man who held definite views of what was due to him in his position as head of a family found it exceedingly difficult to accommodate himself to the fact that his more modern children reacted to him in terms of what he did as a human being, rather than in terms of his position. In breakdowns of individuals holding these viewpoints, it was again found that directive and supportive psychotherapy, with manipulation of the social setting, was the optimal method of approach.

In contrast to this concept of the relationship of the individual to society, patients have been encountered who show themselves as having a relationship which is in a considerable state of fluidity and one, moreover, which they feel depends in great measure upon their own efforts. Where they are ambitious, they see their success or failure as being entirely dependent upon themselves. An interesting form of breakdown of people holding these concepts is represented by those overmotivated individuals who have either insufficient ability to achieve the success at which they aim, or are in positions where this is impossible. The latter situation is beginning to occur with greater frequency, as the major industries become increasingly institutionalized with respect to training, personality and other requirements for promotion. Fortunately, these

individuals are usually rather plastic and melioristic in their approach to the possibility of changing their behavior and, understandably, do well on non-directive techniques.

III. Concept of Organization of Individual

This will serve to introduce the third concept, namely, that as to how the individual himself is organized. In our society, by far the commonest conception of the organization of the human being is in terms of mind, body and soul. The vast majority act, however, as if they considered the mind and soul as one, though on questioning they will usually declare that they are separate. Since the difference rarely reaches practical importance in psychotherapy, they will be treated here as the patient treats them—namely, as one.

The mind-body concept, then, is one of those which has had the greatest possible effect upon the way in which we deal with each other, and not only upon the response to psychotherapy but upon the whole development of psychiatry. At the same time, we must say that it has been the best explored and the best understood of our concepts of human behavior. Possibly when we come to explore our ideas upon the source of power in human relations to an equal extent, these too will be seen to have been equally significant.

To those who conceive of the human being as mind and body, the individual is seen as consisting of a material part which is subject to trauma, breakdown and eventual decay and disappearance, as are the other material objects around us. The mind, on the other hand, is the part which is non-material, which is the "Me" or the "You," the activities of which seem to stop in sleep and unconsciousness, and, which vast numbers hope, persists after the destruction of the body. At the service of the mind is the will, its guide is the conscience. At least in terms of those ideas which have appeared in the last two or three centuries, the mind has freedom of choice.

As we now know, every way of living requires rather considerable manipulation and molding of the instinctive drives, and indeed would not persist without extensive suppression and repression. Hence, when that molding appears to be breaking down—i. e., where deviant forms of behavior appear—considerable anxiety is evoked, not only in the individual but in all those with whom he is in contact. They see, in his failure to maintain conformity, that which is deeply disturbing to them, namely, that their familiar way

of doing things is by no means innate and inevitable but is a structure which is maintained only by continual effort. Moreover, since the individual is seen as having choice in the operation of his mind, and particularly as having recourse to will power, he is apt to be condemned and despised should he show evidence of a so-called mental breakdown. This is in complete contrast to the support and sympathy he is likely to receive if he is suffering from a strangulated hernia.

The writer will not attempt to describe in full the immense ramifications of the effects of the mind-body concept upon the way in which we have dealt with deviant behavior. It is sufficient to stress the fact that it has led to our setting up an exceedingly sterile double classification of physical illnesses and mental illnesses. It has led to our organizing separate hospitals (general hospitals and mental hospitals) to deal with them, each with its separate types of personnel. It has led to our failure to recognize the personal factor in illness, so that vast numbers of people have been, and still are, treated in terms of some limited aspect of their condition, such as a tachycardia or ulcer.

These are great and serious matters. They are recorded to show how far-reaching, how insidious, and how enormously transforming may be the powers exerted by a basic and widely-held concept of how human behavior is carried on.

But our main concern is with how this mind-body concept affects the response to psychotherapy. It may be said at once that it is not infrequently a serious impediment to psychotherapy. This comes about in a variety of ways.

One may first point to the obvious fact that many individuals who see themselves organized as mind and body are unlikely to seek psychiatric assistance for behavioral deviations, but are apt to see them as arising from some local condition. Thus, a woman with a long-term anxiety hysteria, one expression of which was a shaking of her head, claimed that it was the shaking of her head that made her nervous. She spent several years in somatic therapy before finally coming for psychiatric assistance, and even then was by no means convinced that her condition was primarily psychoneurotic. Indeed, when such individuals do come for psychotherapy they are often enough quite untreatable by any psychotherapeutic means. This is apt to be the case where the patient

has undergone a long period of treatment for some peripheral manifestation, especially if surgery has been carried out.

Unfortunately, this mistreatment of psychoneurotic patients continues to be common, since the mind-body concept of the human being is widely spread and is still implicit in teaching, at least in the teaching of the older instructors in medical schools.

A second difficulty appears when the mind-body concept is linked with strong moralistic indoctrination. Under these circumstances, particularly in men, one is apt to encounter such beliefs as that anxiety is being "yellow," or, more generally, that only weaklings are neurotic. Hence it may be difficult for the patient in psychotherapy to penetrate into the fact that his nausea stems from his fear of asserting himself with a domineering superior.

A third difficulty is related to this, namely, that which is derived from the patient's unwillingness to accept the existence of some individual trait, such as hostility toward the mother. Under these circumstances, there is apt to be a focusing of the patient's attention upon some local manifestation, such as a stiffness of the jaw or an inability to swallow. As long as the patient is able to keep this as his principal complaint-problem, he is protected from the necessity of facing the unpleasant situation. Dichotomy-thinking affords him a valuable means of defense.

Again, this type of concept may constitute an impediment to psychotherapy upon the basis of simple misunderstanding and anxiety concerning the patient's symptoms. A common example of this is the complaint of pressure in the head in tensional anxiety patients, which is at times interpreted by them as being due to a brain tumor which the therapist has failed to discover.

Quite apart from the extent to which this interpretation may be symbolic of the patient's guilty feeling that things he has done may have damaged his mind, there remains the tendency to interpret peripheral manifestations in terms of bodily illness, and, moreover, the patient's very anxiety renders it more difficult for him to alter his concept.

Another illustration of the numerous ways in which this mind-body concept of the organization of the individual acts to interfere with psychotherapy is provided by those patients who find in it an opportunity to prolong illness. Quite clearly, if the patient can point to a gastric ulcer, and if he can be sure (as he can be) of the attentions of a physician who will look only at the gastric

ulcer, he will be protected from the necessity of undertaking psychotherapy, and may thus hope to maintain his illness and through this perhaps continue to exert dominance over his family, or, in another instance, may protect himself from the necessity of undertaking an unpleasant move, such as leaving his father's home and setting up in business on his own.

The writer has in general found that patients who hold the mind-body concept can be treated by non-directive techniques. The rise and fall in the intensity of, let us say, their gastric and cardiac symptoms, as painful situations are opened up and then resolved, can be used as means to illustrate and present to the patient the much more effective concepts of the unitary nature of the organism and of its response as a whole to stress applied at any level.

IV. Concept of the Ideal Way of Life

Let us now look at the response to psychotherapy of those who hold different beliefs as to what constitutes the ideal way of life.

It will be recognized that, certainly within the complex societies represented by the modern sovereign states, there exists a variety of ways of life. In the simpler, much smaller societies which have commonly been studied by anthropologists in the past, the way of life followed by people living in each society appears to have been similar and almost identical. But in the complex modern states a considerable variety of ways of living is discernible.

One may point to that followed by those individuals whose habitual attitude to living is the heroic-romantic, whose code is that of strenuous and idealized action. In considerable contrast, there are those whose way of living is the way of passivity—"Not my will, but thy will be done" is intoned, not only in deference to some particular deity but with respect to every man. One may refer, also, to the intensely moralistic way of life, as represented by those who see all aspects of human behavior in terms of right and wrong. There are still others—the aesthetic, the fatalistic and the purely materialistic (one might almost say physiological, and certainly anti-behavioristic) ways of conceiving of human activity. But it is proposed here to confine discussion to a consideration of the first three—the heroic-romantic, the passive and the moralistic.

The heroic-romantic way of life is an activist conception of living. It is an overcompensation with reference to the dangers and

the drabness by which men are alike beset. It idealizes the supreme effort; it places the will on a higher pinnacle than does any other philosophy of life—"You have only to will, to succeed," or Napoleon's dictum—"Moral force is to the physical as three to one," or Roosevelt's, "We have nothing to fear save fear itself." It provides compensation for defeat by idealizing forms of "glorious defeat," "moral victories," and asserting that though the hero may be defeated, and indeed quite dead, his unconquerable spirit leads on.

It does not fail to afford means of transmuting the dull, depressing detail of daily duties. It has given us romantic love and even romantic marriage, enormously over-evaluating the significance of psychosexual interrelationships. This over-evaluation leads inevitably to disappointment, frustration and criticism, both of themselves and of their partners, in large numbers of persons who expect in marriage those magical days and nights that the heroic-romantic way of life so gustily promises.

Now let us say very carefully that all these ways of life which it is proposed to discuss have their utility. They could hardly have persisted down the centuries unless they had had some value in promoting the survival of the individual and of the group. Let us say also that some concepts drawn from all these ways of life are used from time to time by the majority of people. Many of us have justified ourselves in an unpopular minority stand by seeing ourselves as the unrecognized heroes of a future order. Many of us have rationalized our failure to assert ourselves by quoting passive doctrine to the effect that, "After all, there are two sides to every question, and who am I to judge any man." Or again, we have sought to console ourselves for defeat at the hands of some more astute and brightly realistic rival by saying, with the moralist, "I would not want the job if I had to stoop as low as he did to get it." These are the common ways that men everywhere have used to mitigate the hard realities of our society, seeking now from one source and now from another what experience has taught them will best avail.

But what we are concerned with here is, rather, those who have devoted themselves exclusively to one way of life and who must struggle to apply it regardlesss of the actual demands of their situation. We are concerned with the heroic-romantic who must drive himself, and then double-drive himself for the very reason

that his overdriven nature protests. For him, fatigue becomes the whip for increased action, tension the signal for more intense attempt, and wavering concentration for a yet more ultimately concentrated effort.

Here, as in other unrealistic conceptions of human behavior, the primary interference with psychotherapy is found in the patient's unwillingness to seek psychotherapy. This is most particularly true if, as is usual, he holds in addition the widely disseminated mind-body concept of himself. For him, behavioral deviations are mental illnesses, and mental illnesses—at least of a psychoneurotic nature—are things that you can help; only weaklings suffer from them, he believes, and hence he falls back into the old devouring whirlpool of effort and failure, with still greater exertions of will and still more disorganizing failure.

Even after psychotherapy is instituted, one commonly finds that this activist type of individual has great difficulty in accepting assistance, feels that it is heroic to suffer in silence, and hence will not bring out things that are troubling him. He will repeatedly attempt to force himself against his phobias, with consequent failure and demoralization.

Needless to say, the primary approach is through the non-directive therapies, since, for this kind of individual, such a technique is most apt to fit in with his need to feel that he is in some measure the master of his fate. The present writer has, however, usually found it possible, after the intensity of the symptoms has subsided, and after a positive patient-therapist relationship has been established, to get the patient's way of life onto a discussion basis and to show him that there are alternative ways of managing day-to-day living.

Let us turn now to look at an opposite way of life, namely, the passive. Here one puts an end to conflict, not by overcoming opposition by heroic effort, but by acquiescence. In our society, the inculcation of passivity is not so extensive as it was but it is still significant. It starts early, with direct admonitions, of which the grandfather is: "Little boys are to be seen and not heard." Many indirect factors operate toward the production of passivity in the child, the chief being the necessity of competing for scanty attention and the observation that the parent shows preference for the acquiescent child.

When the passive child emerges into adolescent and adult life, he will find waiting for him a whole range of concepts and ideals which will serve to perpetuate this trait. The slogans of going along, of being a good sport, of being co-operative, returning good for evil, turning the other cheek, fit readily into his needs.

When the passive individual comes for psychotherapy, he presents real difficulties in his strong urge to go along. The therapist has to exert the greatest possible vigilance to avoid taking the lead and offering explanations, which the patient will accept, not because they are adequate, but because of his need to go along with the therapist. Moreover, since the passive individual of necessity has a great deal of repressed hostility, considerable time must be spent in endeavoring to have him bring this out, first in the presence of the therapist and then in the presence of those figures having most significance for him, in assisting him through a period of over-assertion, and finally in helping him to work out a more lasting basis of relationship. Throughout this whole period the patient constantly endeavors to gain reassurance and direction; and, in the hands of the inexperienced therapist, he may succeed in working out a parasitic relationship between himself and his therapist, which may last until intercurrent factors break up the therapy.

The third way of life—namely, the intensely moralistic—undoubtedly provides the greatest obstacle to psychotherapy. In the first instance, where as is most common in our culture, the moralism forms part of a religious system, the indoctrination is likely to have been carried on more intensely and over a more prolonged period than in the case of the other two ways of life that we have described. After all, no one has been broken on the wheel or stretched on the rack for failure to obey the dictates of the heroic-romantic or passive ways of life. But though in our society the rights of physical torture are now denied to the exponents of the religious systems, the rights of threat and intimidation, the rights to terrify and misinform the young, are still conceded to them.

Once more, one finds that a certain percentage of individuals following intensely moralistic ways of life do not come for psychotherapy but attempt to find solutions through the immemorial but relatively ineffective methods of that way of life. Those who do

seek psychiatric help often represent our most difficult problems, especially with regard to matters of guilt, and most particularly with reference to sex guilt. It would be hard to estimate how much harm, how much irreparable damage, has been done in our society by moralism's manipulation of sex as a source of power. We have found that many intense and crippling guilt-reactions to masturbation cannot be dealt with through the ordinary techniques of nondirective psychotherapy—the patient is simply unable to take the responsibility of reassessing his beliefs concerning such activities. On occasion, however, especially where a strong patient-therapist relationship has been established, it is possible to attack the problem by directive procedures or by authoritative explanation and reassurance.

Conclusions

Four conclusions are to derived from these studies:

1. That certain of the concepts that we hold concerning our nature hinder our response to psychotherapy. This is particularly true of our concepts concerning the source of power in human affairs, concerning the relationship of the individual to society, concerning the organization of the individual, and concerning the desirable way of life.

2. That some of them, especially when strongly reinforced, prevent the patient from seeking psychotherapy.

3. That those who hold certain types of concept may be amenable to some forms of psychotherapy and not to others.

4. That it is possible to recognize some concepts of human behavior as being actual health hazards. Once this is done, we can hope to approach the notoriously difficult problem of altering the mores, since the sanctions provided in our society by the idea of safeguarding health are outstandingly powerful.

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THE RORSCHACH TEST AND THE QUESTIONS OF "PROGNOSIS" AND "RECOVERY" IN SYPHILITIC MENINGO-ENCEPHALITIS

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I

The subject of syphilitic meningo-encephalitis is one of those chapters in psychiatry which offers a wealth of material for the study of the total personality and of psychosomatic relationships. Kraepelin's masterful monograph, which is both stimulating and provocative of thought, testified to the foregoing statement at an early date. Kraepelin was apparently not satisfied with the idea that the brain pathology in general paresis is the sole responsible cause of the multiform manifestations of the condition. He investigated the possible relationship of various factors such as age, sex, alcohol and trauma, to the problem and concluded that the people themselves, their mode of life, their habits and so forth play an important role in the development of the disorder (in modern language the attitude is one of orientation upon the total personality). As it is well known, Kraepelin differentiated a number of clinical forms of general paresis, such as the demented and expansive. He thought that better knowledge of cerebral localization might explain these variations in the future. This has not yet materialized. Other writers on the subject, such as Schube, discussed certain forms of the disorder in terms of emotional states, which was an important evaluation. However, this approach is one-sided and gives us no clue as to the mechanism and relationship of such manifestations to the totality.

For further elucidation of the subject, the present writers recommend that one apply, toward the problem, the approach of Hughlings Jackson, that is, apply the principles governing evolution and dissolution of the personality. Jackson differentiated "positive" and "negative" symptoms in mental disorder—the former referring to release from control, the latter being understood in terms of functional deficiency. Clinically speaking, there are mental disturbances in which one may deal predominantly if not exclusively with positive symptoms, while in others one may observe essentially negative symptoms; in still others, both positive and negative symptoms may be present. To facilitate interpretation of symptoms and to come closer to the mechanism of

their relationship to the totality, a common denominator in psychiatric disorders was postulated. The common denominator was identified with affectivity, which one of the writers has discussed as the final common path of the total personality. Affectivity is considered the matrix of the positive symptoms. In addition to the common denominator, there may be other factors rooted in various levels of the total personality, which may be considered instrumental in causation of certain symptoms. However, the common denominator may play a role there also. For instance, consider the role of affectivity in the mechanism of recall.

In applying the foregoing to the problem of syphilitic meningo-encephalitis, it is possible to distinguish: (1) structural changes of the brain produced by the infectious agent which may account for such negative symptoms as *loss of memory;* (2) toxic states produced by the same agent, due to disturbed metabolism as well as to impaired function of various viscera and glands, which may account for both positive and negative symptoms such as *misidentification;* (3) the system of defense of the total personality which accounts for positive symptoms, such as *ideas of grandeur.* By means of such an evaluation it is possible to establish the fact (as reported elsewhere) that the depressed and agitated features, as well as certain paranoid states observed in the course of general paresis, are rooted in involutional changes which general paretic patients undergo concurrently with the disease—conditions which apparently facilitate the release of general paretic symptomatology. For details, one may refer to the respective studies.

In the present study, the writers are interested in the questions of "prognosis" and "recovery" in cases of general paresis. Admittedly there are no decisive criteria regarding the questions raised. For instance, Dattner says regarding prognosis: "It has been claimed that patients with depressions offer a less favorable prognosis than those with manic features. In our experience it is difficult to verify this generalization. The type of psychosis is of less importance than the duration and extent of deterioration. One is often surprised with the recovery of apparently demented patients, whereas on the other hand all treatment may fail in seemingly mild cases." Dattner points out further that clinical observation alone is not sufficient for prognosis. Clinical symptoms may become more marked after the syphilitic process has stopped. Again, the syphilitic process may still be active within the central

nervous system, and the patient may be asymptomatic. On the other hand, Dattner says that proper evaluation of the spinal fluid syndrome would enable us with a considerable degree of accuracy to judge the final outcome. The latter is easier said than done. It is contrary to the foregoing observation and clinical experience. We know that the spinal fluid findings are not identical with the disease process but only reflect the process to a certain degree and by no means at all times.

Regarding recovery, Dattner observes: "The patient's ability to return to his former occupation is not at all a valid criterion of success . . . the final decision rests on the factors of duration of life and permanent checking of the infectious process. One must of course wait for many years in order to be able to draw definite conclusions." While the writers agree with the first part of the statement, the last part makes one suspect again that Dattner identifies the problem of general paresis exclusively with the infectious process. This of course is not correct. As it is understood now, it is the total personality that participates both in the release and cure of the trouble. One cannot accept also the requirement of waiting many years for a decision. Efforts are therefore directed toward search for means of acquiring knowledge earlier.

It was with this idea that the writers turned to the Rorschach test, which has proved very fruitful in the investigation of personality. As a projective test, it reflects both organic and affective aspects of the personality. It is thought that the application of the test against the background of the "positive" and "negative" symptoms in general paresis will serve, among other things, as a measure for evaluation of the total situation.

The questions are:

1. Can the Rorschach test offer, in itself or in conjunction with other clinical data, criteria for measuring progress in the course of the disorder—or for measuring progress in treatment, as factors may be established by testing the same patients twice before and after treatment?

2. Can the Rorschach test contribute toward ability to prognosticate decisively?

3. Can the Rorschach test contribute toward our knowledge of what may constitute recovery in general paresis?

II

Before proceeding with the exploration of material, attention is called to certain work which was used as a guide in this investigation. A number of Rorschach workers have occupied themselves with the study of the so-called organic disorders. Among others, Piotrowski has made a notable contribution on the subject. He summarized the findings of Oberholzer, a close collaborator of Rorschach, regarding the matter, essentially as follows:

(a) The organic patient is unable to synthesize well many details into one good interpretation. He is poor in differentiating the more important from the less important.

(b) The organic patient believes that the inkblot represents some definite object which he is supposed to recognize.

(c) There is frequent perseveration and repetition of phrases.

(d) Reaction time is lengthened without exception.

(e) The organic patient gives a large percentage of original responses, but these responses are of poor quality and are inadequate.

(f) The organic patient is interested in his achievement.

(g) The introversive part of his personality diminishes while the extratensive increases. The patient becomes self-centered and extroverted.

Piotrowski attempts to introduce more precise personality data and emphasizes the following:

R. The total number of responses of an organic patient to 10 cards is less than 15. Normals rarely give less than 30 responses.

T. The average response time has been more than one minute. Normals show reaction time of about three-quarters of a minute.

M. An organic patient gives no more than one movement response. Normals rarely give less than two responses.

Cn. The record of an organic case contains at least one color denomination, the simple naming of a color. Normals give no color denomination.

F%. Good form response less than 75. Normals give 80 per cent good form perception.

P%. Popular responses are below 25. Normals give 30.

Rpt. Repetition. The subject gives the same response to several inkblots. This is not perseveration but a compulsion to respond.

Imp. Impotence. This applies to a response which is given in spite of the fact that the subject knows it is inadequate.

Px. Perplexity. The subject distrusts his own ability, and wants the examiner to make up his mind for him.

Ap. Automatic phrases.

The last three findings usually go together.

According to Piotrowski, the presence of five points of the foregoing 10 is suggestive of an organic process. This is denied by some other students, but the writers find it valuable.

According to Piotrowski the presence of *Cn* is indicative of emotional disintegration; and increase in *A%* is suggestive of intellectual disintegration; an increase in *O* is interpreted as inability to adjust to situations in daily life.

Klopfer and Kelley note that the presence of some good responses, along with poor ones, is indicative of a previously higher level of ability, and points to deterioration.

• • •

In reporting the Rorschach test results in an examination of the writers' patients, attention should be called to the fact that while the symbols tend to group themselves significantly as noted by Piotrowski, they cannot actually be equated solely with organicity or affectivity. One can only speak of the dominance of one or another background. This becomes clearer when the symbols are studied on the principle of "positive" and "negative" symptoms as discussed. For example, the following symbols are interpreted thus:

1. *R.* The number of responses may depend on both organic and affective factors. Emotional blocking or functional deficiency may produce the same results. In the writers' cases *R* may be considered predominantly an "organic" feature. It falls in the field of "negative" symptoms.

2. *T.* The foregoing applies here also.

3. *M.* This is essentially affective and a "positive" symptom. In the writers' cases, it becomes a "negative" symptom. This is perhaps the most striking feature of the general paretic process as seen in the Rorschach; and this in turn may point to the influence of organic factors on affective expression.

4. *Cn.* It is interesting to note that Bleuler observed that hallucinations in organic patients manifest themselves mostly in color. In terms of Hughlings Jackson's theory, color naming would re-

fer to a lower level of activity, i. e., engagement of the sensory apparatus.

5. *F.* Generally speaking, *F* is noted in both organicity and affectivity. In the writers' cases, *F* might be considered to belong to a mixture of both "positive" and "negative" symptoms (misidentification).

6. *Imp.—Px.—Ap.* as described by Piotrowski are identified dynamically as *Organic Defense Reactions,* therefore, they usually go together, and are "negative" in character.

7. *Presence of both good and bad answers.* This is accepted as an indication of deterioration as noted by Klopfer and Kelley. It is "negative" in character.

8. *Predominance of anatomical detail.* This is significant for immaturity and poor imagery, but is not necessarily indicative of deterioration—as has been emphasized by others. It is often observed in connection with exaggeration of "Self."

9. *Agglutination.* The writers would like to offer this term with regard to "thought" in general paresis for the following reasons. Kretschmer distinguishes three stages of evolution of thought: (1) agglutination, (2) symmetry and (3) style. Agglutination is thus considered a regression to a lower level and is therefore significant of a dissolution of affectivity. It may be that the term "agglutination" is preferential to the concept of *contamination* used in Rorschach work, a term which seems to refer to the same findings.

10. *Destylization.* This term is offered to signify inability on the part of the patient to form a *Gestalt.* This, like agglutination, is to be understood in Kretschmer's terms regarding thought. Destylization is prognostically a poor sign and is of "negative" value.

III

With the foregoing in mind, 55 Rorschach tests were administered to Manhattan (New York) State Hospital patients. Data reported here are based on the study of 20 male pareties. In addition to the regular clinical investigations, the Rorschach was given in 10 cases before and after malaria treatment, and, in another 10 cases, before treatment only. The patients were followed for one year after release from the hospital. The following cases are illustrative:

Case 1. *R. D.* This man of 33 was admitted to Manhattan State Hospital on January 20, 1944. He was born in the United States in 1910, and was one of two children. His early development is unknown except that it is said he was much attached to his mother. He had little education, "playing hookey" from school. His work adjustment was unsatisfactory; he thereafter did odd jobs in restaurants. He was married at 17, and his wife left him shortly afterward. He resorted to prostitutes and contracted syphilis some 10 years previous to admission. In recent years, he had lived in a common-law relationship with a prostitute. In 1929, he had served in the army and was discharged for medical reasons. He volunteered in 1943 but was rejected because of his previous record. He was moderate in the use of liquor. He is described as being reserved, able to make friends, but rather passive. His output of energy was limited. His intelligence was dull-normal.

The onset of his difficulty is recounted as follows: After being rejected for army service in 1943, R. D. became increasingly depressed. He began to accuse himself of making his "wife" go out with other men, and living at her expense. He felt guilty of neglecting his mother, blamed himself for many things he did not do, and felt people considered him an outcast. Finally he attempted suicide by throwing himself in front of a subway train, following which he was taken to Bellevue Psychiatric Hospital. There a diagnosis of manic-depressive psychosis was made, and he was certified to a state hospital.

Examination showed him to be in good general physical condition. Neurological tests were negative. Blood and spinal fluid Wassermanns were strongly positive, globulin 2 plus, cells 45. Mentally he was described as tense, depressed, self-accusatory. He attempted to hang himself in the hospital. His sensorium was clear. He received a course of tryparsamide which was followed by malaria treatment: eight paroxysms. This was followed by a course of marpharsen.

R. D. was placed on convalescent status on April 4, 1945. At staff presentation for release, he made a good impression, attributed his difficulties to syphilis; evidenced no abnormal ideas and showed no sensorial defects. His diagnosis was psychosis with syphilis of the central nervous system, meningo-encephalitic type. His condition was listed as recovered, the prognosis good.

A Rorschach test at about the time of release showed the following: number of responses 13, no *M* response and inability to use *M* in testing of the limits, poor *F* particularly noteworthy. He showed organic defense reactions. In addition to the organic signs, there was indication of inadequacy of personality and a paranoid tendency. At no time was he able to give even a fair response. On the basis of this test, he was not considered recovered; and the prognosis was considered doubtful.

In the follow-up while on convalescent status, he was noted on May 7, 1945 as irritable, unable to keep a job more than three days, unstable. On June 25, 1945 his wife called the hospital because he began to be abusive and accusatory toward her. He was noted as maladjusted, unable to keep a job, fighting with the landlord and with his wife on September 5, 1945. He was returned to the hospital on March 15, 1946. He escaped April 19, 1946.

Case 2. *V. A.* Male. This Negro, aged 38, was admitted to the hospital on October 31, 1944. Born in the British West Indies February 20, 1906, his early development was unascertained. He had no schooling but could read and write. He had come to the United States in 1926. He worked as an electrician and as a salesman in candy stores. At the time of hospital admission he owned a small stationery store. He was married in 1943, and the marital adjustment was given as good. There was a history of syphilis and anti-luetic treatment, no details known. V. A. used alcohol in moderation. He was described as very quiet; he rarely went out but had friends who visited him in the store. His intelligence was average.

His present difficulty began when the patient collapsed in the store while attending a customer. An ambulance was called and he was taken to Bellevue Psychiatric Hospital where he was seen to be dazed, uncommunicative and confused. His spinal fluid was of the paretic type. The diagnosis was general paresis.

V. A. was certified to Manhattan State Hospital. There, his general physical condition was noted as good. His pupils did not react to light, were sluggish to accommodation; knee jerks were absent. The spinal fluid Wassermann was strongly positive, globulin 4 plus, cells 3. The colloidal gold test showed a paretic curve. The patient was noted to be unstable mentally, but coherent and relevant in his replies. There was a speech defect. He had a vague trend against a woman who may have caused his condition.

He knew he was in a hospital on Ward's Island but did not know the time. His remote memory was considered fair, his recent memory markedly defective. Retention and recall were poor. Counting and calculation were fair, general knowledge was fair.

This patient made a good adjustment on the ward. He received malaria therapy, had eight paroxysms, followed by a course of mapharsen. At the time of his release from the hospital he was noted as having shown a fairly good remission. He denied having any abnormal ideas. His memory was good except for amnesia for the acute stage of his disturbance. The record shows: diagnosis, psychosis with syphilis of the central nervous system, meningo-encephalitic type; condition, much improved; prognosis, fairly good.

A Rorschach test at the time of V. A.'s release is of particular interest. There were no gross Piotrowski signs. The content of the test showed excessive preoccupation with his own body and also with reference to female genitality. In testing of the limits, there was no indication at all of organic disturbance; he gave very adequate and good responses. He was considered recovered, and the prognosis was considered good.

Follow-up notes testified that this patient made good progress. He behaved in normal manner and was discharged on April 15, 1946, at which time he was considered recovered clinically.

Case 3. *D. F.* This man of 28 was admitted to the hospital October 8, 1945. He was born March 15, 1919 in the United States, the youngest of three children. His early development was unknown. He had a common school education. The mother died when he was very young and the boy was taken care of in an institution. He went to work at 15, selling papers, and later became a truck driver. He was married four months before his hospital admission to a woman with whom he had been acquainted for some 10 years. His married life was considered satisfactory. Any history of diseases, injuries and toxic influences was denied. His make-up was given as unstable, his intelligence average.

The onset of his difficulty was sudden. "He became sick while at work. It looked like acute indigestion. He vomited throughout the night. Then he became delirious." He received sedatives but, since he did not improve, was taken to Bellevue Hospital, where he was found to be confused and certified to a state hospital. Upon admission there he was found to be in good general physical

health. His pupils reacted well to light, his reflexes were active. Spinal fluid and blood Wassermanns were strongly positive, globulin 1 plus, cells 12; there was a colloidal gold paretic curve. Mentally D. F. has shown amnesia for the acute episode. Otherwise he denied having abnormal ideas. He was correctly oriented. The diagnosis was psychosis with syphilis of the central nervous system, meningo-encephalitic type. He received malaria treatment—eight paroxysms.

D. F. showed good improvement; appreciated that he had been delirious and admitted hearing voices for a short time while in Bellevue Hospital. He appeared quiet and composed and was placed on convalescent status on December 15, 1945. At the time of his release, he appeared considerably improved but not recovered. The prognosis was considered good.

A Rorschach test done *before* treatment showed 16 responses. There was a prolonged reaction time. Otherwise there was no evidence of organic reaction. The patient appeared to show more of a psychoneurotic pattern. His conflict was sexual; he had difficulties in identification of his own sexuality as well as that of the opposite sex.

The Rorschach test *after* treatment showed an increase in responses to 29. There were *two M's, two FC's.* He further showed much improved interpretation of femininity and masculinity. He was considered recovered and the prognosis was good.

He got along well on convalescent status and was discharged on November 15, 1946, condition recovered.

Case 4. *P. S.* This man, aged 40, was admitted to the hospital October 11, 1945. Born in the United States on February 12, 1905, he was the second of three children. He completed public school at 15. Then went to a trade school and became an automobile mechanic. He was married in 1936; and his marital life was "difficult." He had always been in good health. He was an abstainer from alcohol. In make-up he was "very quiet and seclusive." Intelligence was average.

The onset of his difficulty was given as August 11, 1945. While on a vacation he went for gasoline and failed to return. His wife found him the following night, wandering about. He did not recognize her. A few days later he "ran away" and bought a ticket for Boston, but got lost and his wife found him again. She then took him to Bellevue Hospital where he was found to be quiet, dull

and indifferent, and would not give any information. He was certified to the state hospital, where he was found to be in good physical condition. His pupils reacted sluggishly. There were no pathological reflexes. The blood and spinal fluid Wassermanns were strongly positive: cells 14. The colloidal gold curve was paretic.

Mentally, the patient was dull, apathetic, indifferent. He denied having any abnormal ideas. He was oriented, but his memory was impaired. He did not co-operate well. He received malaria treatment, eight paroxysms, followed by mapharsen. He improved. When he left the hospital he said that he had contracted syphilis 12 years before admission. He gave a fairly good account of his difficulties. He said he could not get along well with his wife, that he had tried to make an adjustment but felt unhappy. He denied having any abnormal ideas. He was released to the care of his brother on January 16, 1946. The record showed: diagnosis, psychosis with syphilis of the central nervous system, meningo-encephalitic type; condition, much improved; prognosis, fairly good.

Rorschach test *before* treatment showed six responses originally and 13 additional on testing the limits. There was no ***M***, but no other organic features. The record reflected a rather obsessional and depressive type of reaction.

The Rorschach test *after* malaria showed a great increase in responses; there were 89. There were 4 *M's*. The patient was considered recovered. The prognosis was doubtful but not for organic reasons.

Case 5. *G. A.* This Negro of 53, was admitted to Manhattan State Hospital May 4, 1945. He was born in the British West Indies on January 19, 1892. His early development was unknown. The boy received a common school education, following which he worked as a carpenter. He came to the United States in 1923. G. A. had been married twice. The first wife died; there were no children with the second. Diseases, injuries and toxic influences were denied. His make-up was given as normal. He was of average intelligence.

The onset of G. A.'s difficulty was about a month before hospital admission, when he became rather excessive in his sexual demands, forgetful and over-religious. He was taken to Bellevue Hospital where he was found to be grandiose and euphoric. He was fairly well oriented. Certified to the state hospital, he was found there to be in good physical condition. His pupils were ir-

regular, unequal, the right larger than the left; they did not react to light but did react to accommodation. Blood and spinal fluid Wassermanns were strongly positive, cells 6, globulin 2 plus; there was a colloidal gold paretic curve. He was observed praying continuously. He was somewhat grandiose and introduced himself as a Moslem clergyman. He was euphoric, but complained of dreaming that somebody was going to kill him. He was oriented correctly; his memory was good. The diagnosis was: psychosis with syphilis of the central nervous system, meningo-encephalitic type. The prognosis and condition were considered fairly good. He had malaria treatment, eight paroxysms, followed by mapharsen. Following this, he became restless and upset. Still later, he became underproductive, refused food and had to be fed. He died on January 4, 1946. The cause of death was given as syphilitic meningo-encephalitis. There was no autopsy.

The Rorschach test of G. A. did not show any striking organic features. However, the impression was that the patient had been under considerable tension, and that all his reactions were "strained." It appeared, further, that the patient was vulnerable to any kind of shock; and, therefore, it was thought that he would not react well to malaria treatment. The prognosis on the Rorschach was poor.

Case 6. *W. W.* A Negro of 41, W. W. was admitted to the hospital September 3, 1945. He was born in South Carolina; his early development was unknown. He had attended common school. He worked as a cook in hotels. He had been married and had had five children, all of whom died in infancy. His wife had died in 1944. He lived with another woman for some two months previous to admission. There was a history of "injections," no details known. This man was moderate in the use of alcohol. He was described as an efficient worker but always wanted to do everything in his own way, rather stubborn, clean and orderly, over-religious. He was of average intelligence.

The onset of his difficulty was about a month before his admission. He had had an argument at his place of work and was discharged. He became disturbed at home, talked a great deal about religion, was excited and upset. He was taken to Bellevue Hospital on September 1, 1945 where he was noted as loud, noisy, hallucinatory. He was in good physical condition. The diagnosis was schizophrenia. The patient was certified to Manhattan State

Hospital where he was found in good general physical condition: the blood pressure 124/70, pupils regular, equal, reacting sluggishly to light and accommodation, the reflexes negative. Blood and spinal fluid Wassermanns were strongly positive, globulin 3 plus, cells 10. The x-ray of the chest was negative, the urine negative. The man was ambulatory, in good general condition, friendly and co-operative, normally productive, happy. He admitted hearing voices and seeing things; he said God was talking to him; he could see God showing him a place in the mountains where he would find his soul. The patient's orientation was noted as good, his memory fair. The diagnosis was psychosis with syphilis of the central nervous system, meningo-encephalitic type. After admission W. W. became very disturbed, noisy, destructive, and continued to be hallucinated. He had shown no acute physical symptoms except that on September 28 it was noted that his eyes were bloodshot. He died September 29, 1945. Because the patient died while in restraint the case was referred to the chief medical examiner who conducted an autopsy and gave the cause of death as "exhaustion psychosis."

The Rorschach test of this man did not show any organic features. The patient apparently labored under severe mental anguish rooted in sexual conflict. He violently refused to handle the Rorschach cards—with an expression of extreme pain and torture in his face. He said, "It is bad . . . pure blood . . . only the pure in heart will see God." The prognosis was considered poor.

IV

Upon analysis of the case material, the following comments seem pertinent:

The patients could be divided grossly into three groups: one in which the clinical findings approximately coincide with the Rorschach; another in which the Rorschach findings reveal additional information of both organic and affective value, particularly with reference to the psychodynamics of the case; and a third in which the clinical record contains pertinent information not obtainable by the Rorschach. This general statement is illustrated in detail by the following data from the material studied.

Case 1. Clinically, the diagnosis of general paresis was made, as usual, on the basis of serological findings. The mental picture, as described, was distinctly one of a manic-depressive, depressed

type of reaction. There were no sensorial defects and no neurological signs. In fact, on the observation ward the patient was thought to be a case of manic-depressive psychosis. Upon release from the hospital he was considered clinically recovered; and the prognosis was given as good, although some doubt regarding the latter could be had because of inadequacy of personality. The Rorschach test, however, revealed organic features which were considered due either to underlying mental defect or to an organic process. Moreover, he had shown a paranoid tendency, he was not considered recovered; and the prognosis was given definitely as unfavorable. In this case one may score an advantage for the Rorschach test as against the clinical record in respect to both condition and prognosis.

Case 2. Clinically, there is definitely an organic syndrome here (both physically and mentally). Upon release this patient has shown a good remission, and the clinical prognosis was fairly good. The Rorschach test missed the organic features. By the test results, the man was considered recovered and the prognosis seemed good. Here the Rorschach test and clinical findings coincide with regard to the questions raised. The Rorschach failed in clinical evaluation of the organic reaction.

Case 3. Clinically, the record revealed an organic reaction (confusional state for a brief time). Upon release, this patient was judged to have a good remission, and the prognosis was good. The Rorschach test was done at the time the patient recovered from the confusional state, and, hence, revealed no organic features. Otherwise, the Rorschach findings approximately coincided with the clinical findings. There was some greater illumination of psychodynamics by the Rorschach examination but that may have been due to the fact that insufficient time was allowed for the study of the case clinically.

Case 4. Clinically, this patient showed few, if any, organic features. The syndrome was schizophrenia-like. The Rorschach findings approximately coincided. However, the prognosis from the Rorschach results was more guarded, not because of the paretic process, but by reason of the psychodynamic findings.

Case 5. Clinically, the patient demonstrated upon entrance to the hospital an expansive type of reaction with ideas of grandeur

and a paranoid attitude. There were few organic features. After malaria he showed regression, became hypochondriacal and displayed involutional symptoms. He refused food and failed rapidly. On admission the prognosis appeared fairly good, later, doubtful. It is of interest that the Rorschach examination pointed to the severity of the patient's conflict and the poverty of his defenses, as well as the fact that he would not do well with malaria. The Rorschach prognosis was poor. The patient died; and, while the cause of death was given routinely as syphilitic meningo-encephalitis, the true cause appeared to the writers to be exhaustion, basically emotional, with the mechanism on the physiological level as described in a former study (Davidson 1934).

Case 6. Clinically, the patient showed a catatonia-like reaction. He was alternately happy, ecstatic, excited, agitated, etc. There were no outstanding organic features. The prognosis appeared guarded. The Rorschach test here, as well as in Case 5, revealed certain very interesting phenomena. There were no organic features in the Rorschach results. In contrast to external expressions of elation, as described in the clinical record, there was Rorschach evidence of severe mental anguish, continuous polarization of emotions, self-condemnation. The prognosis appeared poor. The patient died, the autopsy gave the cause of death as "exhaustion psychosis." Regarding the mechanism, one may refer again to the study previously cited.

Conclusions

One may conclude, therefore, with reference to the questions raised that: (1) The Rorschach test is a valuable contribution toward ability to measure progress in the course of syphilitic meningo-encephalitis, as seen in Cases 3 and 4; (2) the Rorschach test contributes toward our ability to form a more adequate prognosis, as demonstrated by the cases cited; and (3) the Rorschach test contributes also toward our knowledge of what may constitute recovery in general paresis.

Finally, one may repeat that general paresis is a psychosomatic disorder and that the Rorschach test is of considerable value not only regarding the questions discussed here, but also in evaluation of the situation as a whole.

The prognostic value of the procedure, however, is greater than the diagnostic.

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EDUCATIONAL THERAPY IN A PUBLIC MENTAL HOSPITAL

BY NEWTON BIGELOW, M. D., AND BERTRICE CLARK, A. B., B. S.

Having in mind Elliot Paul's adjuration, "Whatever isn't growing, wears out," a project in Educational Therapy was started July 21, 1947, at Marcy (New York) State Hospital.

The following excerpt from the *First Annual Report* of the New York State Lunatic Asylum at Utica, from the opening of the institution January 16, 1843 to November 30, is pertinent:

"SCHOOL"

"We have long been desirous of seeing, in lunatic asylums, systematic efforts to cultivate the minds of patients. For this purpose we have established schools, two for the men and one for the women, and our highest expectations of good results have been more than realized.

"Among our attendants and convalescent patients are those accustomed to teach. These take charge of the schools. They commence at ten and two, and continue from one to two hours. The best of order prevails. The patients read in rotation, and sometimes at once, spell, recite pieces they have committed to memory, attend to arithmetic, history and geography, assisted by maps and blackboards. Many attend to writing and some have here first learned to write. We have no more beautiful sight to present than our school rooms, where the patients may be seen engaged in their studies with all the sobriety and ardor usually seen in other schools.

"The school is beneficial, especially to the convalescent—those that are melancholy—and those who appear to be losing their mental powers and sinking into a demented condition.

"Those who have recovered, but continue with us for fear of a relapse, and to test the permanency of their recovery, derive both pleasure and profit from attending. Those that are melancholy and depressed are beguiled from their sorrows, and for a while made to forget them, and thus the way often is prepared for their restoration.

"Those who appear to be losing their mental powers are much benefited by this daily and regular exercise of their minds; their memories improve, and they become more active and cheerful.

"The want of proper mental occupation, according to our observation, is one of the most pressing wants of lunatic asylums. Notwithstanding amusements and labor many are constantly disposed to sit still, absorbed in their own thoughts and delusions, and thus continually becoming worse.

"Schools, we believe, will do much towards remedying the evil to which we allude, and the expense attending them is but trifling."

Some of the educational principles and projects outlined by Burlingame at the Institute of Living, were modified consistent with differences in the Marcy population. The primary objective was to supply intellectual stimulation in a social setting, in the belief that, for some of the population at least, this factor had been only partially considered. Secondarily, evenings generally are rather dreary in a state hospital, considering that work, occupational therapy and formal recreation almost invariably end before the evening meal.

The extreme diversity of the intellectual and cultural backgrounds in a state hospital population presented the primary obstacle. Major difficulties also encountered were lack of staff, materials and classrooms. Finally it was necessary to "sell" such a plan to the personnel and to the patients.

After considerable discussion and taking-of-thought, the program took shape. Having in mind that workable patterns of belief and conduct are best molded by humanitarian pursuits, it was felt that this field should receive due attention. Time was when reading, writing and arithmetic covered the major part of what was called education. Now, even in grade schools, the curriculum when graphically put down, looks like a glorified old-fashioned grammar-school diagram of a compound sentence. Roughly divided, there seem to be two types of subjects: *tools,* such as grammar, mathematics, science (the arithmetic of the old days); ***humanities,*** like language, history, music, religion, and the arts. This second group corresponds to the reading-writing part of the old curriculum, plus the homework of "those good old days." Whether it is old or new-style education, the ratio seems to remain approximately 2 to 1 in favor of humanities.

Thus, the Marcy school began with Language, Music, Current Events, and Household Arts. Some of the women students complained that they had been arbitrarily excluded from Current Events. It was therefore arranged for the men to take Practical

Mathematics on the evening when Household Arts was given, and for both groups to attend the course in Current Events. Because the presentation of the material for Music involved analysis and discussion of compositions, some class members asked for an opportunity to listen quietly to music without interruption, and accordingly such a period was added to the project.

The course in Language centered about three themes: personality development, grammar, and the production of a newspaper. The goal of the first is expressed in the slogan: "To say what you mean, to talk and someone listens." The *King James Version of the Holy Bible,* the *New Winston Dictionary,* Tressler's *English in Action, Book II,* and Foerster's *Sentences and Thinking* were drawn upon freely. The second field, grammar, which was studied as the tool of good English, was based on Newman's *Easy Steps to Correct English.* In this are outlined 50 routine lessons such as "Verbs Lead An Active Life" or "Exposing the Habits of Tricky Negatives." General Semantics *per se,* was not used, although basic principles were utilized. From a purely utilitarian standpoint, the course had value over and above the intangible benefits of exposure to fine prose, good sentiment and lofty thinking. Spelling bees were not successful at the start, because of the embarrassment of those who missed. Subsequently these contests were tried again with success, perhaps because class technique had improved. Four issues of the *Marcy Mirror,* the final project, were written and edited by the class. The community aspects of this venture were probably its greatest value.

Music was taught with the aid of records and the personal demonstration of the orchestral instruments. After seeing the how and where of musical notes, singly and blended, and after listening to rhythm and harmony variants, the group studied the common musical forms. There was active participation by class members in the demonstrations and in the discussions. Three outgrowths came from this course: It is to be noted that some of the students themselves requested the opportunity for quiet listening, and this was arranged. Community singing likewise originated in this group and provision for this was made on Sunday evenings. Finally the group sponsored a series of concerts for the enjoyment of the entire hospital population, in which artists from the community appeared. Programs ranged from those given by the hos-

pital band to performances by excellent string players, orchestras, choral groups, and an outstanding presentation of classical-boogy-woogy piano music.

In Current Events, the third item on the curriculum, the procedure consisted of assigning a topic to a student for the following week's discussion. This had precedence over the material brought in by other members of the group. A weekly news map, the *New York Times,* the *Herald Tribune,* and *Time* magazine were drawn upon freely. Incidentally, this class had a high record of attendance.

Household Arts included nutrition, cooking, cleaning, laundry, budgeting, interior decorating, wardrobe, motherhood, the training of children, hygiene, recreation, and even some elementary carpentry, plumbing and electrical installation. Considerable use was made of graphic charts and emphasis was placed on personal and community health.

Practical Mathematics, the parallel course for men, was divided at first into two sections, elementary and advanced, with a slight variation between the two. However, the strong helped the weak, and both groups seemed to enjoy it. Although the course centered about practical mathematics, standard high school texts were used for reference. Later, simple engineering problems and measurements were added.

It was generally agreed among the instructors that, because of the relatively rapid turn-over of students, all class programs should be simple and each one a complete unit. The student body was limited to 20, equally divided as to sex. Eligibility requirements were a high school education and possession of ground privileges. A reserve list of approved candidates was kept current. The faculty included an occupational therapy instructor who taught language and administered the program. She also assisted in some of the classroom work. Music was taught by two physicians whose avocations lie in that direction. The classes in Current Events were also conducted by two members of the medical staff, one of whom had had experience with group therapy while in military service. Household Arts was the responsibility of the dietitian who conducted her course enthusiastically and who maintained that the homemaker runs the world's smallest but most important institution. Mathematics was taught by a social worker and a second occupational therapy instructor. This group of

teachers was an earnest one, thoroughly convinced of the value of the work, and interested in the progress of the students, especially with respect to their social adjustment. They gave freely of their time and energy. Student classes met four evenings a week from 6:05 to 6:55 p. m. in lecture or occupational therapy classrooms and in one kitchen. In a great measure the equipment was also improvised, but there were paper, pencils and some small mathematical instruments, the reference materials already named, a blackboard, a record player and a rather extensive collection of records. The hospital library afforded a valuable source of additional material.

A standing committee met regularly to discuss principles, procedures, and ways and means, as the instructors felt their way along. Whereas the first meeting was colored with considerable skepticism and hesitation, the one at the end of the first school year was characterized by a feeling of accomplishment and confidence. Everyone present had something of interest to contribute and all then felt that final unity had been reached.

With considerable enthusiasm the second year was begun with double the enrollment and classes five evenings a week at 5:45 p. m. The same five departments were continued.

Under Music, the concert series was greatly expanded. Participating artists and orchestra conductors never failed to congratulate the general audience on demeanor and close attention. The musical period for quiet listening expanded into the assembly hall, and one formal session each week was devoted to this. In competition with performers from the community, this group participated at the annual Christmas entertainment. The fundamental course of instruction in music appreciation was continued.

Mathematics centered around practical engineering problems and business arithmetic. A sample class included the following: The first 20 minutes was devoted to a General Motors film illustrating internal combustion. During the remainder of the period, addition and the theory of the "minus nine" for rapid and accurate checking were taken up. Near the close of the period a student introduced the theory of teaching numbers to the young with idea association instead of the old-fashioned abstract method. Free discussion resulted in divided opinion.

Household Arts continued to have a definite structure of personal, family and community health problems. New devices and time-savers were described. Emphasis was laid on diets and care

of the teeth—the latter followed up by talks by the hospital dentist. A study of the institutional methods of "keeping house" was made. Beginning with the matter of conservation of resources—and as a result of personal experiences in Europe during the last war, related by a staff member—a hospital-wide project to collect tinfoil to help provide beds for crippled children was initiated in this class. Current Events was the "most discussion-minded class of the year." The new "Geographic Point-of-View" slant added tremendously to the interest.

The Language class continued with the same aims. However, the students asked for more outlet for self-expression, and participation in dramatics was suggested. Choral reading was the first step, and was much enjoyed. Three editions of the *Marcy Mirror* were published, one of which was devoted to a write-up of the hospital farm based upon a personally-conducted tour. During the second year, much greater use of visual aids was made. These seemed to capture interest, and dressed up some of the presentations materially.

The occupational therapy instructor was again responsible for the program during the year. Also on the faculty were seven members of the staff, three attendants and the hospital dietitian. Actual teaching hours were refunded, but the hours of preparation were donated. None had been trained in the teaching profession, which may be salutary. Teaching techniques are changing rapidly and it may be that there will be less to discard than if the faculty were formally trained.

As it does not seem practical for various—and obvious—reasons, to evaluate this course statistically, the reactions of the patients, as expressed to instructors, may be the best measure of the success of this educational therapy. The benefits seen by the patients themselves naturally varied with their personal needs and tastes, and with the courses in which they found the greatest interest and enjoyment.

Patients participating in the Music Appreciation course, for example, all seemed to benefit from the group situation and to develop a feeling of being unified in sharing the experiences that each encounters as an individual in the group. There was not so much group discussion in the music appreciation classes as in some of the others. However, some evidences of individuals becoming re-socialized were noted. The class seemed to divide itself at first

into three groups: One which never entered into the discussion, one which took part more or less normally, and a third smaller group which was inclined to demand the limelight in the discussion. After several months the class took on a more homogeneous atmosphere. Some were encouraged by the efforts of the stabilizing individuals; those who were reluctant to speak in class became better able and more willing to express themselves. On the other hand, those inclined to monopolize the stage had to relinquish it, at times because of group pressure rather bluntly placed on them.

Enthusiasm on the part of a few individuals in the Music Appreciation group resulted in library research work, voluntarily undertaken and reported back to the group. This encouraged others to do the same.

One woman patient, now on convalescent status, voluntarily stated her belief that the music educational classes played a large role in her recovery from dementia præcox and in becoming more at ease in a group. It is of interest that this individual was the only one who at any time was acutely upset in class. This was manifested by crying, irrational talking and acute anxiety while listening to a recording. The group showed patience, tolerance and understanding while the instructor was assisting the patient. She was back in the class the following week, and there was no evidence that the rest of the class blamed her. She seemed as much at ease with the group as she had been before her disturbed period.

Many times following the music class period, one or two patients would express their appreciation to the instructor for a pleasant evening, or for a particularly instructive session.

One patient wrote the following letter to her instructor several months after being placed on convalescent care: "It is 11:15 P. M. but I've just come from a concert I really enjoyed so much. This is my third concert of the series and I have enjoyed them completely. Thanks to you and those music appreciation courses you promoted. Thank heaven I gave up flirting and listened to you at those sessions."

Some other spontaneous comments follow:

One student, an attorney with dementia præcox, paranoid type, said: "Participation in the classes gives one an opportunity to refresh one's memory on various subjects, to learn new material, to

discuss the subjects, to sing and to enter into group meetings. The classes are ably instructed. I have been helped by the classes."

Another class member with dementia præcox of long standing commented in part: "More patients should be induced to join our night school. I believe that our instructors can estimate the patient's ability and thus help more patients. Really, I have no criticism concerning our night school. Truly it is much appreciated by me since the school is educational and worth while. More stress should be placed on the public-speaking course, both prepared and extemporaneously. Our Current Events course is splendid and must continue. Our opinions are many times as good and better than those of our salaried legislators. Our Music Appreciation class is excellent."

Another patient, a case of dementia præcox, paranoid type, reported the following: "One evening the Household Arts class showed a film which gave insight into amazing changes over a period of a century. Current events discussions serve to pool information and keep us up to date. Geographic topics were engaged in enthusiastically. Emotional nature is very indicative of personality and is reflected by reactions to musical study. Also, music hath charms to soothe the savage beast."

Although, as has already been noted, the results cannot be measured statistically with any justice, the tables for the two annual sessions give some of the facts. (Table 1 and 2.)

TABLE 1. SESSION 1947-1948

Subject	Meetings	Average attendance Men	Women	Both	Student hours
Music					
Appreciation	27			16	432
Listening period*	17			43	731
Group singing	3			23	69
Current events	6	9			54
Current events	22			15	330
Language	32			16	512
Mathematics	14	8			112
Household arts	17		8		136

Totals

Number of students registered	83
Student attendance hours	2,322
Number of meetings held	138

*Note: Patients (without ground privileges) were invited.

TABLE 2. SESSION 1948-1949

Subject	Meetings	Average attendance Men	Women	Student hours
Music				
Appreciation	28	13	13	728
Listening period	6	10	7	102
Group singing	28	14	16	840
Currents events	24	14	11	600
Language	28	14	12	728
Mathematics	27	12		324
Household arts	27		10	270

Totals

Number of students registered*	122
Student attendance hours	3,594
Number of meetings held	168

*Note: 19 were repeats from the previous year.

SUMMARY

Two years of an educational therapy program, reaching some 200 state hospital patients, have convinced the writers of its several tangible and intangible benefits. Difficulties, curriculum, procedure and progress have been described. Objectives cannot be described better than in the *First Annual Report of the New York State Lunatic Asylum*, dated at Utica in 1843 and cited in the foregoing.

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FURTHER STUDIES ON DEPERSONALIZATION

BY EDMUND BERGLER, M. D.

In a lecture delivered before the Vienna Psychoanalytic Society in December 1933,[1] the present writer came, in collaboration with L. Eidelberg, and on the basis of an extensive clinical material, to the conclusion that the depersonalized neurotic labors under the following conflict. An *anal-exhibitionistic* repressed wish is warded off with *pleasurable self-voyeurisim;* that defense, too, is prohibited by the inner conscience with the result that a *secondary* unconscious defense is installed: "I don't peep at myself, I just *mournfully observe my sickness.*"

It is a well-known fact that the depersonalized individual constantly observes himself—changing himself, to use Theodor Reik's apt phrase, into a "psychic observatory." This constant self-observation is not a by-product of the sickness, as previously assumed, but an integral part of it.

But the question remained unanswered: Why is the starting point precisely *anal* exhibitionism? No answer could be found at that time—a clinical observation was merely reported. The extensive analytic literature did not provide an answer either; although, as Schilder remarked, "The number of interpretations offered for this fascinating picture is almost limitless."[2]

Further experience during the last 15 years has convinced the writer, first, that the *scopophiliac "exchange mechanism"* is the basis of the neurotic disease entity—depersonalization;* second, that the therapeutic pessimism so frequently voiced is unjustified; third, that a specific answer can be found for the typical anal variety of exhibitionism predominant in depersonalization. The answer hinges on *beating fantasies;* depersonalization seems to represent *one of the many possible attenuated end-results of "a child is being beaten" fantasy insofar as it is executed with scopophiliac means.*

Here is the experience which provoked the thought of an interconnection between the phenomena, later confirmed in four other cases. A Canadian woman of 36 entered analysis because of severe depersonalization. The symptomatology was typical; she

*The disease entity "depersonalization" must be distinguished both from transitory symptoms of depersonalization, occurring frequently at the high points of all types of neuroses, and from depersonalization encountered in schizoid-schizophrenic states.

said that she was *"constantly"* suffering under "quite severe" "feelings of unreality," and, what was subjectively even worse, was "constantly" frightened "to death" of a "great attack" of the unreality feeling. That "great attack" had been experienced by the patient for the first time 10 years before. At that time she left the home of her husband (after five years of marriage) allegedly to visit foreign countries, especially France, and to write a book. In reality, she felt unhappy in her marriage (she was frigid), and this was aggravated by the presence of her mother-in-law who overstayed her welcome during a visit, originally planned for a couple of weeks. The attack, consisting of panic—"I'm losing my mind, am completely unreal; I feel as though I had broken loose from everything, a swimming feeling"—resulted in her returning to her husband after a few days.

A few months later, she started her explorations in foreign countries once more, and entered into an affair with a ship captain whom she had met abroad on her first trip. She experienced full orgasm. Without ostensible reason, she returned after six months to her husband, but continued the affair with the captain during the following three years. The break came when the captain insisted on her divorcing the husband and marrying him. During the next eight years she had felt but "mildly" depersonalized. However one year before entering analysis a sudden and "full-fledged" attack set in. She had been (as usual) "drinking moderately" one day while reading a dreary English novel centering around two unhappy spinsters. She got up to turn off the radio music and "couldn't believe in the reality of the radio." Her panic lasted for half an hour, and subsided slowly, only to return shortly afterward at the dinner table. Feeling unable to fight off further attacks, she underwent psychotherapy and later spent six months in a sanatorium where insulin shock and superficial psychotherapy had been employed. Finally, she started psychoanalytic treatment.

The patient described her situation in childhood as one in which she was completely dominated by a malicious, irrational, petty and sponging father. The mother was submissive to the father's whims. The child had but one confidante, her grandmother. The patient described that woman in glowing colors; one had the impression that that aggrandizement was based on demotion of the mother, who nursed her for four months only and had left her

during her first year of life in the grandmother's care for a whole year while she herself traveled west to take care of the father, stricken ill during a trip to the west coast. At the age of 10, the intimacy with the grandmother was interrupted because the patient's family moved into another part of the country.

The father ridiculed her, but, on the other hand, wanted her to stand first in her class. She disliked him intensely, heaped all her hatred upon him, finally severed relations completely with the family. She married at the age of 22 a young man "with whom she could talk." The husband was a "friendly, shy, reticent, understanding and forgiving person." He had been deeply attached to his wife, and refused the divorce she wanted, condoning her peculiar behavior and protracted escapade.

The patient presented characterologically the typical picture of an "injustice collector." She had not one but a dozen "chips on her shoulder." A series of facts in the case history pointed in the direction of *oral regression*: her drinking, her being an *inhibited* writer, her "*injustice collecting.*"* Last but not least—her *blushing* and *erythrophobia.*

In the transference, she quickly projected upon the analyst a series of "injustices." She felt "uncomfortable," constantly looked at her watch, as if trying to escape some danger. She refused to produce associations; she refused to use the couch. She treated both requests as personal malice on the part of the analyst. The former request was "impossible," the latter refusal was a precaution against "stronger feeling of unreality when in that position." Both attitudes gave the possibility of analyzing her exhibitionism, also facilitated by a dream during the first days of analysis. The manifest contents of the dream were:

"A *cow* is bleeding from a wound in the side; I *observe* horrified at the scene standing somewhere in the *rear,* till a veterinarian arrives."

Attention was drawn to the fact that when on the couch, she "exhibited" herself seemingly from the rear; her refusal to associate corresponded once more to a defense against exhibitionism ("to reveal oneself"); in the dream she observes the cow from the back, the wound being also on the side or back. Why that super-

*For theoretical elaboration, see the writer's: *The Basic Neurosis.* Grune & Stratton. New York. 1949.

abundance of direct or defensive showing of herself and of peeping?

To this, the patient could not contribute anything but a conscious recollection. At the age of five she was taken by her mother to the bathroom and watched her *father* take a bath. Thus shifting to the father, she said ironically: "Obviously, I don't want to allow you all the pleasure." It turned out that in her previous treatment, her blind hatred of the father was allowed to pass; all her troubles were explained as "fixation to the father."

It was shown to the patient that her transference was truly a *mother* transference, later in life fastened to the father image. It was explained that she obviously identified herself with the "cow" in the dream. (In another layer, the cow being the mother, the dreamer was watching her own sadistic-masochistic misconception of sex.) Attention was focused on the sequence of wish and defense—anal exhibitionism being warded off with peeping. In her refusal to use the couch, she "prevented" the analyst *—with whom she identified herself*—from being a "voyeur." Only this pertained to her, and not to the by-chance physician.

Interestingly enough, the material presented "convinced" the patient: She accepted the exhibitionistic-voyeuristic "exchange." In a long series of "refutation dreams,"* she defended herself against exhibitionism, e. g., "I am on the beach, everybody is naked, I am fully dressed." She protested only against dragging the weak mother into her "story." She maintained that the real malefactor of her life was—in her opinion—her father, and adduced convincing reasons to prove his malice and irrationality. All this was, however, but a secondary shift.

The patient's psychic masochism had been warded off with extensive pseudo-aggression. She constantly "took the blame for the lesser crime," fastening her guilt to alleged aggression toward the family. That blind guilt too, had to be discarded and the guilt put where it belonged intrapsychically: to her psychic masochism of pre-Oedipal origin.

What was the connection between beating fantasies and depersonalization in this case? The patient had very vague recollections of her father beating her. Later, better recollections came, the

*For theoretical basis, see: On a predictable mechanism—enabling the patient even in the beginning of analysis to check the veracity of interpretations. Psychoan. Rev., 1945. See also: *The Basic Neurosis.*

father using a leather strap, a *cane* or a broom. Of course, she remembered only being beaten, and the pain; the alluring pleasure, was fully repressed. A little incident convinced her: Her favorite easy chair was made of a bamboo-like material called rattan. She spent all her free time sitting in that chair. She could not explain exactly how that chair (belonging previously to the *mother*-in-law) should have escaped her frequent re-decorations of her apartment at which times she literally threw out most of the old "stuff." She toyed during analysis with the "inexplainable word": "*ratatouille.*" The word was first meaningless; later she remembered that it means in French slang "*ragoût grossier,*" coarse stew. She pronounced the word "*rattatue,*" which gave first the impression of "*tuer,*" the French equivalent for killing. The writer drew attention to the fact that it could be possible that she had created a synthetic word composed of "rattan" and "*tuer,*" and asked her of what material father's cane was made. It turned out that it was rattan-bamboo. Thus the word meant: The beating "kills" me. Hence, in toying with the word, she accused mother ("bad stew") and *father!*

Sitting with her buttocks in the chair, she exposed herself to the hated—and loved—bamboo, alluding to recollection of Chinese torture and beating methods.

The whole impact of the patient's repressed beating fantasies could be approached—paradoxically—through her erythrophobia. In two previous papers,[3] published in 1938 and 1948, respectively, the present writer tried to prove that an enlargement of Freud's original formulation, described in his famous paper, "A Child Is Being Beaten,'" had become necessary, a necessity prompted by Freud's own discovery of the pre-Oedipal phase of development. This enlargement, covering the substructure, presumed first that the child's aggression was originally directed toward the mother's breast and was only secondarily shifted under pressure of guilt, later sexualized guilt, toward its own buttocks. After the "executive" has been shifted from mother to father, Freud's original tripartite scheme applies: "My father beats a child whom I hate—I am beaten by my father (repressed)—a father substitute is beating boys."

On the other hand, in erythrophobia,[3] the two cheeks unconsciously have the meaning of the two breasts; that pre-Oedipal substructure is changed later, in the Oedipal phase, in the exhibi-

tionistic penis-connotation of the head. The sequence of inner events is: I want to gaze (tear, bite) at mother's breast; first super-ego reproach; first defense, "I don't want to peep, I exhibit *my* breasts (cheeks)"; second super-ego reproach; second defense, "I am afraid of making a spectacle of myself, I blush." In blushing, however, both warded-off scopophiliac wishes are smuggled in: By blushing, the erythrophobe centers attention on himself, hence exhibits; by unconscious identification with the spectator, he peeps at—himself.

The patient discussed used both defensive techniques: She fought her unfinished "battle of the breast" with cheeks and buttocks. To complicate matters, the scopophiliac problem entered the picture, leading to erythrophobia and depersonalization.

The *connection* between *beating fantasies,* executed on the *buttocks,* and depersonalization, warding off *exhibitionism of the buttocks,* appeared to be this: In both cases, the masochistic battle has been fought on "foreign territory," buttocks substituting for breasts. The unconscious identification of breasts and buttocks (a well-known phenomenon repeatedly described by different authors, especially in dream symbolism) was so important to the present patient because by exhibiting as a child the breast-buttocks, she could *negate the lack of breasts,* one of the possessions mother had, but which she, however, missed. Thus the exhibition of the buttocks was already a *defense,* used also as *masochistic invitation to be beaten.*•

It seems that *in cases in which beating fantasies are combined with extensive scopophiliac tendencies, depersonalization is used as a typical defense mechanism.*

The combination of beating fantasies and exhibitionism, explains also why the patient so readily remembered the scene in which she was present when father took a bath. In this convenient recollection the guilt was shifted: *Not,* she, *Father* exhibited! Not *she,* was peeping, Mother *forced* her to look!

We see in the patient a long series of desperate attempts to shift the scene of the original conflict and the *dramatis personae.* The "battle of the breasts" becomes the "battle of the buttocks";

•The preponderance of scopophilia and beating fantasies perhaps explained also why no recollection of infantile masturbation could be elicited. It is possible that the combination of puritan education plus the real satisfaction of beating tortures, overshadowed direct masturbation.

the conflict with the mother is transferred to the father. It was, however, precisely the pre-Oedipal fixation which prevented even a normal and full-fledged development of the Oedipus complex. The latter was in this patient's case always imbued with pre-Oedipal connotations. In her choice of husband, she proceeded on the defensive level: A weak, passive man is chosen to disprove her masochistic wish to be tortured. Even normal activity in a man was feared by the patient—every activity being identified (unconsciously, to be sure) with being pushed into the passive-masochistic position. Therefore, she could not divorce her husband, although she was frigid with him, and refused to marry the lover, although she experienced full orgasm with him.

In her depersonalization, she succeeded partially in escaping the too-dangerous territory of the breasts; she exhibited her buttocks, thus denying the "loss" of the envied breasts. The blame is taken for the "lesser crime"—*exhibitionism* substituting for the masochistic wish to be beaten.* Interestingly enough, the external factor, seemingly preceding the second "great attack," was the "unreality of the radio." She was, as mentioned previously, just turning off the radio, when the attack set in, making her doubt the "reality" of the radio. The unconscious reason was: The harmless announcer's voice is silenced (willfully by her), action should follow. Transposed to the infantile situation: Father stops shouting and starts beating. At precisely that moment, where the buttocks should be exposed, depersonalization sets in.

The first attack of depersonalization was preceded by a similar situation. She had just escaped a *woman's* tyranny (she had left the country to escape her mother-in-law); her attack of depersonalization *brought her back in four days!* The "slave rebellion" was of short duration, the allure of mistreatment and exhibitionistic substitutes proved too strong.

All of these desperate attempts to escape, and disguise by inner shifts, the original conflict with the pre-Oedipal mother, proved in-

*The father's attitude fostered the idea that exhibitionism "isn't so bad," e. g., father remarked at her graduation day: "You were not the first in your class, but at least you were the girl with the best legs!" Much earlier, the father promoted the idea that the girl should become an actress. Her "shyness" (defense against exhibitionism) made this, of course, impossible. Her pronounced exhibitionism was (because connected with beating fantasies) strongly repressed: She did not want to take off her coat during appointment!

sufficient. In certain areas of her personality, even the secondary shift to father did not work: in *drinking, writer's block, injustice collecting, blushing.*

Analytic experiences with alcoholic addiction prove conclusively that an unresolved masochistic conflict of the "I want to be refused" variety with the pre-Oedipal mother lies at the bottom.* In the first—"jocose" phase—mother's power is "eliminated" by the defensive "proof" that one can get as much fluid as one wants —from other sources. In the "morose" phase, the reproach of conscience returns, with respect to the masochistic wish to be refused. The next defense—the *"bellicose"* phase—uses stronger defensive arguments, hence the destructive outward behavior. Parallel with that attitude, an unconscious identification with the mother takes place: The alcoholic fills *her* with poison. The fourth phase—popularly called the "comatose"—is that of hangover and guilt.

Hence, this patient's drinking represented both a *pseudo*-aggression toward her mother *and* a self-damaging, masochistically-tinged, self-destructive attitude, all expressed by liquid means.

The deep *oral-passive*-masochistic attachment to the image of the pre-Oedipal mother, had been unconsciously fought by the patient by two other *pseudo-aggressive* and *autarchic* means: her predilection for cooking and—attempts at writing. She was an excellent and discerning cook, thus counteracting both culinary dependence on the mother and her reproach that she had been served poor food, as expressed in her pun of uneatable stew (*"ratatouille"*). On that battlefront, she was quite successful and ingenious in devising new concoctions. The other—sublimated culinary—battlefront, that of writing, was more or less a losing proposition. She had no great difficulty in imagining a plot (voyeurism), the real trouble started with the writing and working it out (exhibitionism). She did manage to write a few stories, even a whole book—for children and adolescents. Here her cherished

*See: Contributions to the psychogenesis of alcohol addiction. Quart. J. Stud. Alc., 19:295-310, 1945. Also: Section 26, Ch. VI., *The Basic Neurosis.*

"magic gesture" entered the picture defensively: I show you how I wanted to be treated—kindly.*

The patient's writing block related to her inability to solve her masochistic attachment to the mother. In the writer's opinion, the writer "sets up shop" autarchically: He refutes the unsolved psychic masochistic attachment to his mother, by "denying" her very existence: he *gives himself out of himself* beautiful words and ideas.**

It was also interesting that the "fear of being drained" (the reversal of her own draining tendencies) was very pronounced: The patient rationalized her "retirement" from the family by pointing out that her parents would sponge on her and her husband's money.†

Finally, her fear of being *"at any moment"* and *"without warning"* subjected to an "attack of unreality" found its simple explanation in the *father's unpredictability in his beating procedures!*

It was interesting to the writer that the obvious idea of connecting *anal* exhibition and *beating* fantasies, did not occur to him (or to anybody else, for that matter) earlier.

In re-reading the case history of a patient, analyzed 20 years ago,‡ the writer did find a passage referring to attenuated beating fantasies:

"Another game instituted by father (the patient's father) consisted of acting as a 'scout,' approaching the patient, the latter bent over a table, then administering a 'tender slap' to the girl's buttocks. It became apparent that the patient provoked that game time and again; neither the father nor the patient ever marvelled at the fact that she found herself so frequently in the rather un-

*Magic gestures have a three-layer structure: masochistic complaint, defensive pseudo-aggression, finally a "harmless" demonstration of how kindly one allegedly wanted to be treated. For elaboration, see: The problem of magic gestures. PSYCHIAT. QUART., 19:295-310, 1945. Also: Section 26, Ch. VI, The Basic Neurosis. Magic gestures played an important role in this patient's life.

See, *f. i.*: Psychoanalysis of writers and literary productivity. In: ***Psychoanalysis and the Social Sciences.* I. (Géza Róheim, editor.) International Universities Press. New York. 1947. Summary in *The Writer and Psychoanalysis.* Doubleday. 1950.

†This attitude was also repeated in her sex life: She was either tender though refusing sex, or she unconsciously pushed the husband into the situation of the refusing mother, by his "denying her pleasure"—she was frigid.

‡Published in: *The Mechanism of Depersonalization.* The quoted passage is to be found on page 271.

usual position of being bent over the table. The father could not understand how it was possible that the girl could hear his approach and at the 'decisive moment' make a half turn to the father. . . ."

The interesting feature in that case was that the father was rather kind and never punished the child. Still, the child developed these beating fantasies: They referred to the mother.

As piquant detail* pertaining to the present patient (the Canadian woman), I would mention the fact that after the connection between anal exhibitionism and beating fantasies had been clinically established in her case, she confessed: "The moment you mentioned anal exhibitionism, I thought, 'It must have some relation to father's beating!'" . . . "Why didn't you say so?" . . . "Well, this was months ago." That is paradigmatic for the "help" patients give us!

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*Another detail was her occasional boredom. The writer suggested in his paper "On the Disease Entity Boredom ('Alysosis') and Its Psychopathology" (PSYCHIAT. QUART., 19:1, 38, 1945) that depersonalization, erythrophobia and alysosis should be subsumed under "scopophiliac diseases." For interconnections, see that paper. Despite relatively extensive clinical material on depersonalization (the writer reported several cases in 1933) he has encountered only twice neurotics who combined *all four* manifestations of scopophilia (blushing, depersonalization, boredom, writer's block). The one is the case reported here, the other was described in "Further Contributions to the Psychoanalysis of Writers I," Psychoan. Rev., 34:4, 464-465, 1947. In these cases a peculiar oscillation in the "scopophiliac exchange mechanism" is observable: the constant defensive change from voyeurism to exhibitionism and vice versa.

CHLORAL DELIRIUM*

BY EDWARD L. MARGETTS, M. D., C. M.

A. Introduction

Chloralism in any form is now rarely diagnosed. The chief reason for this is that the drug has been replaced by more readily available hypnotics, particularly barbiturates. Some of the drug-states spoken of or reported as bromide intoxications may be due, at least in part, to chloral, which has been taken in the well-known chloral and bromide prescription mixture. The toxic effect of chloral on the heart (*vide infra*) has deterred a great many physicians from prescribing it. Since the last case of chloral delirium reported in English was in 1907,[1] it is felt that the following case will be of interest.

B. Report of a Case of Chloral Hydrate Delirium

1

Admission to Shaughnessy Hospital (D. V. A.) Vancouver, B. C. G. C., aged 52 years, was admitted January 9, 1948 with a history of a recent third heart attack. The admitting doctor noted that the patient was heavily sedated, drowsy and incoherent. His respirations were slow, his temperature was normal, and his pulse was 92. The patient was confined to bed and treated as a coronary case. He soon became restless, complained of pain in his chest and back, and constantly asked for sedatives. He exhibited inappropriate laughter, was on the verge of weeping at times, and was disoriented. These facts led the internist to request a psychiatric opinion, which was offered on January 11.

At that time the findings were as follows:

The patient was a tall, pale, debilitated man who had obviously lost weight. He was quiet and co-operative. His lips were grossly tremulous, his outstretched fingers were moderately so, and his face and scalp musculature showed rapid fine twitchings. His skin was dry and moderately warm, and there was a good deal of scaling of his scalp and branny desquamation on the margins of his eyelids. The conjunctivae were suffused and edematous. Pupils were 4.0 mm. in diameter in ordinary light, equal in size and

*This paper represents work done while the author was a resident in psychiatry at Shaughnessy Hospital (D. V. A.), Vancouver, B. C.

shape. Both, but particularly the right, reacted rather sluggishly to light and accommodation. Eye movements were well performed. Ocular fundi appeared normal. His tongue was dry, smooth, transversely furrowed and mauve-colored. Blood pressure was 175/110 and the pulse was 90 and strong. Percussion indicated that the patient's heart was not grossly enlarged. A systolic apical murmur was noted and there were occasional extrasystoles. The radial arteries were elastic and moderately thick, and the retinal arteries showed no undue sclerosis for a man of his age. Muscle power was generally decreased. The results of cranial nerve examination were essentially negative, sensation was normal, and there was no muscular inco-ordination. Plantar response was normal.

G. C. gave a fairly well-arranged story, was correctly oriented with respect to place and person, but disoriented as to time. Emotional response to questioning was appropriate, although ordinarily his face reflected a flattened affect, and at times apprehension and suspicion. He talked well, in the cultured manner of an educated person, and did not exhibit pressure of talk, flight of ideas or blocking. He was likely to lose control of his speech, and he did rather poorly on tongue twisters, but there was no actual slurring. Memory, retention, recall, and concentration were impaired. Perception, apperception, and judgment were faulty. The patient was bewildered, and misinterpreted his environment; for instance, he called a clock a radio. He complained that his hearing and sight had deteriorated lately, and that his eyes were smarting and sore. He said that noise bothered him, and he had his ears plugged with cotton-wool in an effort to block out sounds. He said that during the previous night he had noticed a humming in his right ear, "as though electricity was escaping from a fixture." He had the idea that the matron had paddled a nurse with a ping pong bat that the patient had given his grandson for Christmas. He believed that a man called Paddy had "gone nuts," barricaded himself in a nearby room with a couple of revolvers, and was singing over a radio, "Ducks, ducks, ducks over the marshes." He thought that the admitting doctor was feuding with a white-haired woman, a well-known rifle shot, because of "professional jealousy over a medical subject." This woman was holding the patient's wife and daughter as hostages, and was "after information" of some sort.

Paddy quarreled with this woman and wounded her, and she fell out of a window.

The findings were in keeping with those of a toxic delirium. Close questioning of the patient's wife revealed that he had been taking large doses of chloral hydrate daily for one and a half years. The diagnosis of chloral delirium was thus established.

G. C. was seen again the next morning. He was lying quietly and calmly in bed, and was co-operative as before. Facial twitching was less apparent. He stated that the previous evening he had understood that there were men on the roof opposite with machine-guns shooting at high-flying ducks, and he was afraid that they might spray his window. These men were soldiers who had been called in to "get" Paddy. "It all ties in with this Palestine sniping business." The white-haired woman was shining spotlights in his window "so she could see everything that was going on". (There actually were floodlights on the roof which shone in his window.) He also said that Paddy's granddaughter had been singing an Irish folk-song on the roof. These delusions, auditory hallucinations, and illusions were strictly nocturnal at this time. One should comment here on how bizarre, disconnected, and contradictory was the patient's ideation, and how it was conditioned almost entirely "from without," i. e., by stimulation from his environment.

2

History of present illness. The patient suffered a coronary infarction in April 1945. Prior to this illness, he had been a hard worker, outgoing, interested in everything, and liked to be in the center of activity. He was a "nervous type," anxious but capable and methodical. He could not, however, be considered to be suffering from a neurosis or personality disorder. At the time of this coronary episode, the patient was under the care of Dr. T., who called in Dr. F. as a cardiac consultant. While G. C. was in hospital, Dr. F. prescribed frequent chloral hydrate as a sedative. The patient remembered nothing of his 17-day hospitalization, so he probably had sufficient chloral to keep him stuporous. His family was led to believe that he would not survive his illness. The patient then spent three weeks in bed at home, attended by Dr. T., who changed the medication to rectal paraldehyde. During the next year, the patient received various hypnotic drugs, including

nembutal, trional, carbrital, phenobarbital, triple bromides, morphine, pantopon, and demerol. During this year, he did not appear to feel particularly sorry for himself, although he chafed at being kept in bed or in the house, and his wife stated that it became an "obsession" with him to have a sedative at night in order to sleep. G. C. was anxious to return to work, and was offered a very good position, but Dr. F. advised that it was "impossible," because of his "severe cardiac illness." Later the same year, the patient was offered another job, and he was told by the same doctor that it was unlikely he would ever be able to work again outside his home.

During the year from the summer of 1945 to the summer of 1946, the patient was treated for edema of the lower limbs. From July 1946 he was attended by another doctor, P., who started the patient on a Schemm diet. Dr. P. attempted to discontinue all sedatives, which at that time were barbiturates. This was tried for only eight days, during which the patient was extremely restless, sleepless, and depressed. He threatened to jump out a window if he did not receive a hypnotic, so in August 1946 he was again put on chloral hydrate, and had taken it regularly until his admission to the hospital.

In the autumn of 1946, G. C. apparently had a second coronary infarction, and in the spring of 1947, he developed a phlebitis of the left leg. Further symptoms appeared, particularly restlessness, headaches, insomnia, dimness of vision, nightmares of prison camps, loss of weight (50 pounds from 1945 to 1948), and impaired sexual power and libido. These were not recognized as caused by chloralism, but were considered to be symptoms of a neurotic anxiety state. Commencing in September 1946, the patient's wife, without his knowledge, started to dilute his prescription with water. She did this consistently from that date until his admission. The patient took the drug daily from August 1946 until October 1947, but accurate amounts were not ascertained for this period. The amount of chloral taken over the three-month period prior to his admission was accurately established as follows: Average amount of chloral hydrate per day, grains 40. From January 4 to 9, 1948 (the latter the day of admission), per day, grains 120.

In December 1947, the patient had begun to complain of feeling miserable, with sub-occipital headaches, pain under the left an-

terior rib margin and back, decreased appetite, very sensitive skin, weakness of the wrists, and scaling of scalp and eyelids. He was assumed to have an attack of "flu." Around the New Year, his wife noticed that he was "not so quick mentally—duller—not so quick at a comeback." He became increasingly unsteady on his feet, stumbled a good deal, and his speech was "thick." On two occasions between January 1 and 4, 1948, the patient fell in the night while looking for his sedative. On January 4 at 1 a. m., the patient fell out of bed, and at this time suffered what was considered to be another coronary infarction—he exhibited contortions of face, poor color, faint irregular pulse, and complained of pain in his chest. He was seen by Dr. T. later in the morning, who instructed the patient's wife to sedate him with chloral as required. This was done in the quantities stated until he was admitted to the hospital.

3

Past relevant history. G. C. was born in Ireland, and came of a good family. His father was a tailor, a quiet, hard-working man, who was very gentle and fond of his children. He died at the age of 50, apparently of erysipelas after a turbinectomy. At this time the patient was 29. The patient's mother was an intelligent woman, a good conversationalist, a firm Baptist, and a church worker. She had a very quick temper, and was prone to have "bilious attacks" with vomiting and headaches. The patient regarded his mother as the dominant person in the home. He said that his father and mother were not particularly close or demonstrative to each other. His mother had married at 30, being some years older than her husband. The patient was the eldest of three brothers, four years older than the next sibling, A., and six years older than the youngest, W. The patient felt that he was favored by his mother until A. suffered a traumatic paraplegia at the age of 12. His mother then transferred her affections almost entirely from the patient to the invalid brother. G. C. maintained that he had never felt jealous of this switching of attention, because he was always too busy with his own pursuits to feel very rejected about it. Although he was never a close friend of A., he had always admired him greatly for the way in which he adjusted to his infirmity.

The patient said that W. was the "queer" one of the three—"clever but lazy." After World War II W. was pensioned for disseminated sclerosis, with some question of hysterical coloring.

No history of childhood neurotic traits, habits, or behavior difficulties could be established in the patient. He was an occasional drinker and a moderate smoker. He was well educated, having attended university and normal school. Until the onset of his coronary disease, he had worked as a teacher (mostly of radio and electricity in technical schools), as an executive secretary to the mayor of a city, as a personnel officer, and as a business man (radio sales and repairs). He was always economically secure, and lived a comfortable life. He had seen service in World War I, and had been a prisoner of war for two years in Germany. While a prisoner, he had tried to escape three times, and was successful on the third attempt. During the stress of solitary confinement, he had developed mild claustrophobic anxiety attacks and panic nightmares. The patient was married to a nurse in 1920, and they had three daughters, to whom the patient was very attached. There were apparently no domestic or sexual maladjustments.

4

Progress on Psychiatric Ward. By serial electrocardiograms and other clinical tests, it was proved that G. C. had suffered a recent coronary infarction. All laboratory tests, including cerebrospinal fluid examination, were negative except for the findings generally found in coronary infarctions.

JANUARY 12. The patient was confined in a locked observation room. Continued to be delusional, "jittery," and nervous at times, and misinterpreted all sounds, including music, voices, and miscellaneous noises which he heard on the ward. He thought that someone was running around with a gun to kill Paddy's son.

JANUARY 13. G. C. was apprehensive and afraid of voices. He insisted that Paddy was confusing him with another man, having the same name as the patient, a local racketeer and a "no-good." He told a nurse that she was wearing his sister's clothing, declared that a syringe of vitamin B_1, which a nurse injected into him, was loaded with germs, and he felt that he was being punished. He complained that there were "maggots" in the hospital, a distortion of the physician's name, "Margetts"! He remembered the month, but not the day or year. He was oriented as to person, but

did not remember that his wife and daughter had visited him the previous night. He saw "gas" swirling in his window. This he felt was being directed at him by Paddy. The "gas" may have been an illusion (fog) and not a hallucination, but it was rather likely the latter. In an attempt to evade his persecutor, he tried to get out of the window by "juggling" with the fixtures.

JANUARY 14. The patient developed the delusion that Paddy was trying to saw through a beam in the ceiling so that he could shoot him or throw a knife or hatchet at him. In cutting through the beam, Paddy had hit a water pipe, and the patient complained that water was dripping from the ceiling. He asked to have his mattress removed so it would not get wet. He was suspicious and apprehensive.

JANUARY 15. He felt that his brother A. was being murdered—that Paddy had captured him while A. was at the hospital taking paraplegic exercises. Paddy was so rough on A. that even Paddy's friends were protesting. G. C. heard the voices of Paddy and his men transmitted down an air vent leading into the toilet near the observation room, and he was positive that he heard a radio, either above him or below him, over which he heard broadcast the details of a conspiracy against his family.

JANUARY 16. G. C. asked to have his door locked, because Paddy was singing, "Gordon is cracked, (mind broken down), he must go, he has wrecked our radio." The patient believed that Paddy and his friends were torturing and disfiguring his wife and daughter by putting adhesive tape over their mouths and eyes and then ripping it off and exposing the raw flesh underneath. All the while, his persecutor "laughed insanely." Paddy was sawing through the ceiling with the purpose of dropping it upon the patient. This claustrophobic reaction was related to panic nightmares of walls closing in on him, which the patient had suffered while in a German prison cell during World War I.

JANUARY 17. Paddy and his gang were now digging under the floor in an attempt to get at G. C. He heard Paddy broadcasting, "Gordon C. is rolling on, Gordon C. is rolling on, Gordon C. is going down below"—i. e., to a secluded pit under the stairs, where nobody ever went. Paddy had caught several of the patient's relatives and imprisoned them there, and aimed to wipe out the whole family. By mistake, Paddy also incarcerated some outsiders, but felt that it did not matter because he was so deep in crime anyway

that it made no difference. The pit finally became so full of people that some of them were smothered.

JANUARY 18 AND 19. The patient was becoming very doubtful about his delusional system, and was apparently beginning to accept the explanation that most of his fears were purely on the basis of subjective thinking, largely misinterpretations of stimuli in his environment, distortions of events in his past life, and unwarranted apprehensions about his future.

JANUARY 20. G. C. noted that his delusions, hallucinations, and illusions were more noticeable to him when he was fatigued mentally, and after eating meals, particularly supper. He was informed, at this time, of the fact that he had suffered another coronary infarction. This bad news depressed the patient considerably, but he soon became resigned to it and co-operated very well in limiting his activity. However, the resulting psychic trauma seemed to exacerbate his psychosis, which temporarily became more obvious. He felt that his persecution was humiliating and unjust, heard Paddy say over the radio that he was going to cut off the patient's legs at the ankles—"going to chop both my feet off with an axe so I'd be like my brother."

JANUARY 21. Paddy rhymed over the radio: "Gordon C. has guns all over him, guns all over him, guns all over him," etc. (tune of the *Old Gray Mare*). "Guns" was related to "Gunn's Tire Repair Shop," which offered radio news every morning. G. C. heard Paddy thumping and banging upstairs. This belief was an auditory illusion—plumbers were working upstairs at the time, and making considerable noise. The patient heard clicking noises like the firing of an empty automatic pistol, "It would seem that it (the firing) was being directed against me." This was also an illusion derived from the clicking of the electromagnet in the physician's signal board in the hall. G. C. felt that since Paddy could not get at him "physically," he was trying to drive him "nuts" by getting at him "mentally," by clicking the pistol to "get his goat." The patient had no more delusions that his family was being persecuted, "That's gone." He had seen his wife and daughters regularly, and was convinced that they were safe. Tremulousness about the patient's face had pretty well disappeared.

JANUARY 22 TO 26. Delusions, hallucinations, and illusions faded over this period. G. C. felt that he could avoid them by interesting himself in work or recreation. He tried very hard to put them out

of his mind. When emotionally upset, he noticed faint rhyming as before.

JANUARY 27 TO APRIL 2. From January 31 on, no hallucinations, delusions, or illusions could be elicited. The patient's physical condition greatly improved, with gains in weight, color and strength. The patient was discharged April 2, 1948. He was seen on two occasions after being discharged from the hospital.

APRIL 23. G. C. looked very well, had put on weight, and his muscle tone had increased. He was "getting along fine" and was most grateful for the treatment he had received. He was still bothered with insomnia, but it was slight, and he was improving. Libido sexualis had returned almost completely, although there was some difficulty in obtaining an erection.

MAY 28. The patient reported that his sexual power had returned to a level approaching that before his illness. Several complaints were referable to the heart, e. g., dyspnea on exertion; and most of these were brought on by overdoing physical work in his house and garden. He was making plans to obtain part-time employment, as had been advised.

5

Treatment. The treatment of G. C.'s cardiac disease was along the usual lines. At the time of his discharge from hospital, he was not receiving any pharmacological treatment for his heart condition.

During his delirium, this patient received small amounts of paraldehyde as required. Very little other than nightly soporification was necessary. After several weeks, this hypnotic was changed to triple bromides, which, in turn, were varied to barbiturates. At the time of his release from the hospital, the patient was not receiving any sedation at all. He was more active than he had been in three years.

He had intravenous fluid consisting of 50 cc. of 50 per cent glucose, 100 mg. of thiamine chloride, and 15 to 35 units of crystalline insulin. For the first three days this mixture was given twice a day, and for the next five days, once a day. In addition, the patient received massive doses of nicotinic acid and vitamin B complex by mouth, and thiamine chloride intramuscularly unless it had already been given intravenously. Other treatment consisted

of continuous warm baths, saline enemata, mild catharsis, and the bathing of his eyelids with boracic acid solution.

From the beginning, intensive explanatory, suggestive, and persuasive psychotherapy was carried out. A practical, friendly doctor-patient relationship had a good deal to do with G. C.'s comfortable recovery. Deep psychotherapy of a non-directive nature was not indicated. The first day he was seen, the patient was repeatedly told that he was mentally upset because of overdosage of chloral hydrate, and he was told also that his confused state would last for about three weeks (a good guess—it lasted 22 days). The desirability of correct orientation, and the necessity for realizing that his beliefs were mostly subjective and distorted evaluations of events in his environment and in past experiences, were stressed to him. Most of G. C.'s delusions about his relatives being persecuted were disseminated by having his family visit often. There was no doubt that his recovery was aided a good deal by placing him in a quiet, well-lighted room, because extraneous sounds such as conversation, music, and miscellaneous noises were misinterpreted by him, and twisted into bizarre and illogical beliefs.

An important factor in this patient's recovery and eventual rehabilitation was talking over with him the fact that for three years he had been an invalid, actually unnecessarily, because of his belief that he had severe incapacitating heart disease which prevented him from enjoying even moderate activity. It was explained to him that in spite of his cardiac disability, he could adjust well and carry on light work.

6

Psychological Tests. A Wechsler-Bellevue Intelligence Test was carried out on February 18. G. C.'s full scale I. Q. was 125 (superior), verbal scale 131 (very superior), performance scale 112 (bright normal). Testing revealed an exceptionally broad vocabulary and verbal facility, a drop in performance efficiency, and disharmony between basic mental endowment and functioning level of intelligence.

Three Rorschach tests were done, the first on January 12, when the patient was confused, the second on February 25, when clinically clearer, and the third on April 23, when considerably improved. In all three Rorschach records, the form level of each separate concept was good. However, the patient combined these re-

sponses into bizarre wholes, with no inhibition and no apparent subjective discomfort. For example, the responses to Card IV on January 12 were:

(1) "An almost human form—dog-like imitation structures. Joined together quite evenly, a well-balanced drawing by some sort of a conjunctural figure representing some birth form. (2) There's a projecting arm which looks like the head of a goose—joined by the base of the neck and also by tendons to the body from the throat of the goose. (3) The whole thing rests on four-hoofed feet. The outside of the lower figure is rough and blurred." On February 25, the patient denied that the goose was actually joined to the rest of the form, which was seen then as fleece. On April 23, the W tendency was explained by the patient on a fairly rational basis, although some vestige still remained in a certain "concreteness" of response. The confused, repetitive material characteristic of Record I was not present in the subsequent records, although the patient continued to be pedantic, as if attempting to impress the examiner with his broad vocabulary. The patient's use of C′ increased with each test. He seemed to obtain the same subjective satisfaction from the gray and black as he did from the bright colors. There was no color shock in any of the records, but a long delay with Card V, Record 1, suggested possible black shock. Acute shading disturbance was present in Record 2. The persistent color description, hardly distinguishable from color naming, and the many "concrete" responses, suggested that organic changes might be irreversible.

C. Discussion

Liebreich[2] introduced chloral hydrate into medicine in the year 1869, and the drug became a popular hypnotic and sedative. Its drug effects were utilized by many people as a means of escape from the drudgery, ennui, unhappiness, tension and illness of a competitive, demanding world. Among those who became chloral habitués were Dante Gabriel Rossetti (1828-1882), the English poet and painter; Friedrich Nietzsche (1844-1900), the German philosopher; and Karl Ferdinand Gutzkow (1811-1878), the German writer.

The toxic effects of chloral hydrate soon became established. Elliott[3] was one of the first to report in English a case of "delirium tremens after chloral drinking." He noted, "There was no appre-

ciable difference between the disease as seen in this case and in one where alcohol has been the predisposing agent." MacKenzie[4] and Da Costa[5] also discussed chloral delirium.

Since 1906, only 11 clinical reports of chloralism of any type have been listed in the *Index Medicus*. Not all of the cases reported have been those of pure chloral hydrate poisoning. Many were those in which the patients took other drugs, particularly alcohol,

QUANTITATIVE RORSCHACH ANALYSIS

		Record I Jan. 12	Record II Feb. 25	Record III April 23
Manner of approach	W	10 22%	11 25%	10 17%
	D	17 41%	22 50%	36 61%
	Do	1	—	—
	d	6 14%	5 11%	6 10%
	DdS	10 22%	6 14%	7 12%
	Total R	44	44	59
	Covering part of blot and edging	frequent	present	less frequent
Determinants	M	5	5	8 +2
	FM	7	8 +2	12 +1
	m	— +1	1 +1	1 +2
	Fk	—	—	1
	FK	—	1	— +1
	F	20 45%	14 32%	18 31%
	Fc	4 +2	3 +4	1 +3
	c	2	—	2 +1
	C'	2 +2	1 +8	4 +7
	FC	3	6 +1	4
	CF	+1	1 +1	5 +1
	Cdes & Cn	1	4	3
Content	H	6	4	5
	Hd	2	2	4
	A	10 34%	11 34%	14 36%
	Ad	5	4	7
	Obj	10	6	9
	P	5	7	7
	O	1	3	3
Proportions	H+A:Hd+Ad	16:7	15:6	19:11
	M: Sum C	5:3	5:10	8:11½
	FM+m:Fc+c+C'	7:8	9:4	13:7
	% to 8, 9, 10	27%	32%	39%
	W:M	10:5	11:5	10:8

opium, morphine, cocaine, or bromides, in conjunction with chloral, or had psychiatric disabilities, the signs and symptoms of which distorted the true picture of chloralism when the latter developed. Only one case of actual delirium has been reported in English since 1906: This was by Mitchell,[1] who presented a case of noisy, hallucinatory, delusional, disoriented psychosis in a man who had been taking chloral hydrate for 15 years. An interesting paper by Chopra and Chopra[6] described 40 cases of chronic chloralism in the Sikhs of Ferozepore and Ludhiana, in the Punjab. The authors saw no cases of delirium. They noted that chloral was taken with a view to gaining intoxicating effects, and that it was often used mixed with, or as a substitute for, alcohol, which was at the time becoming increasingly expensive. The natives frequently took opium along with the chloral. Rather surprisingly, these authors regarded chloral as by far the most dangerous drug of addiction.

Since 1906, there have been three French reports on chloral delirium. Antheaume and Parrot[7] mentioned two cases of chloral delirium reported by Ballet,[8] the first pointing out the similarity between *délire chloralique aigu* (*a potu nimio*) *and delirium trements alcoolique*, and the second pointing out the similarity between *delirium tremens chloralique* (*a potu suspenso*) and *délire alcoolique aigu*. Antheaume and Parrot's case followed the pattern of Ballet's second, and they noted that the symptomatology recalled that of general paresis. Clérambault[9] reported two cases of acute chloral delirium superimposed on chronic chloralism. He attempted to present a differential diagnosis between delirium resulting from intoxication by chloral and that caused by other drugs. Kahn [10] very briefly discussed a case of "chloralomanie." Six other foreign papers have appeared on clinical chloralism since 1906.[11, 12, 13, 14, 15, 16]

One has to go to the older textbooks to find any written word on chloral delirium. Calandraud[17] reviewed some of the literature. Maudsley,[18] who examined Rossetti (*vide supra*), noted, "Of chloral hydrate, as frequently used, I entertain a bad opinion, and I much fear that its discovery has been thus far, not a good, but an evil, to the human race . . . The worst cases of insanity which I have seen have been cases in which large and repeated doses of chloral have been given for some time." He mentioned that the drug had been called "crystallized hell." Krafft-Ebing[19] noted

that continued use of chloral led to moroseness and depression, and mentioned that withdrawal led to hallucinatory delirium resembling delirium tremens. Savage[20] noted that "Chloral hydrate, if taken in very large doses, may cause stuporous dementia or profound melancholia. In continual doses it leads to some moral perversion, and may give rise to delusions of persecution. It may start sensory illusions and hallucinations, but these are not very common. Stupidity, slowness of reaction, doubt and suspicion are the most common symptoms produced by its prolonged use." Dercum[21] described chronic chloralism and stated: ". . . attacks of delirium may supervene which bear a marked resemblance to delirium tremens; or the patient may be mildly confused, and there may be both visceral and auditory hallucinations. The confusion is, as a rule, not active, is attended by depression and may superficially suggest melancholia." Schroeder[22] and May[23] discussed chloral psychosis briefly.

The mental aspects of chloral intoxication are described in only a few of the textbooks of psychiatry, neurology and forensic medicine of the last 25 years. Stoddart[24] noted that he had never seen a case of chloral delirium tremens. Palmer[25] stated, "Addiction to chloral hydrate has been reported, although it is undoubtedly extremely rare," Chronic chloralism was well defined in the ninth edition of Taylor's *Jurisprudence*,[26] and it is briefly noted, "In severe cases symptoms of delirium tremens may supervene." Diethelm[27] stated, "Chloral hydrate offered in high amounts over a long period of time leads to delirium which lasts about two weeks, during which the patient is usually quiet, watching with interest the many small animals and small men which they see in their hallucinations. These hallucinations usually disappear after the light is turned on. Some develop delirium tremens-like reaction; in others affective features (anxiety and depression) predominate . . . chloral hydrate delirium is rare. . . ." Billings[28] wrote, "Chloral hydrate produces an interesting delirium in that the patient is relatively quiet and watches with interest the small animals and men that he visually hallucinates only in the darkness." Lévy-Valensi[29] described two forms of chloralism, a *"forme agitée,"* with insomnia, agitation, hyperesthesia and anxiety, and a *"forme dépressive,"* with retardation or sluggishness (*torpeur*). He also noted that there was a *"delirium tremens chloralique,"* which resembled that of alcohol, with trembling, fever, sweats, and Lillipu-

tian hallucinations. He suggested that perhaps the delirium was produced by an excess or withdrawal of chloral. Wilson[36] in 1940 noted, "chloralism, now doubtless rare, not to say unfashionable, was rife for years after the introduction . . . often assuming the clinical form of delirium tremens. . . ."

Chloral intoxication may be conveniently divided into three main clinical groups: (1) chronic chloralism or chloral habituation; (2) acute chloral poisoning; (3) chloral delirium. The case presented in this paper is an example of chloral delirium superimposed on chronic chloralism. The following list is a composite one of signs and symptoms that have been present in cases of chloral intoxication reported to date, and in the patient described in this paper. It must be stressed that some of the findings listed in the older literature may not have been due to chloralism but to concomitant physical or mental disease of another type. This is because the descriptive studies have been based on single isolated cases, and not well-controlled series in which influences other than chloral can be removed or properly discarded as non-contributory data. There seems to be little that is specific about the physical or mental findings in chloralism which might not be seen as a result of intoxications by other drugs. The objective and subjective psychiatric findings appear to depend largely on the pre-morbid personality and experiences of the patient. Paranoid reactions are possibly the most usual. Microptic hallucinations have been reported as typical, but this finding must be questioned in view of the scanty evidence. There are a few somatic findings more or less characteristic of chloral. These include suffusion of conjunctivae, lacrimation, smarting eyes, scaling of eyelids and scalp, cutaneous vasodilatation, and an odor of the drug on the patient's breath. Many of the signs and symptoms listed for one group in the following may be found in another—in particular, the chronic findings are likely to be seen in the delirium which is usually superimposed on chronic chloralism.

1. *Chronic Chloralism*

(a) *Physical manifestations.* Loss of weight, generalized wasting, weakness, hypovitaminoses, myalgias, arthralgias, general instability, tremor, ataxia, inco-ordination, paresthesias (e. g., formication, burning, tingling, etc.), hyperesthesia, hypoesthesia, anesthesia, decreased or increased reflexes, epileptiform convul-

sions, neuralgias, headaches, vertigo, blurred vision, cranial nerve palsies, diplopias, speech disturbances (e. g., slurring), gastric irritation (e. g., nausea, vomiting, anorexia, constipation, diarrhoea, coated tongue, bitter taste in mouth, acrid smell from mouth), conjunctival suffusion, yellowish conjunctivae, lacrimation, conjunctival burning and smarting, conjunctivitis, heavy and ptosed eyelids, dry skin, vasodilatation, erythema, papules, pustules, purpura, urticaria, scaling eyelids and scalp, palpitations of heart, pulse arrhythmias, feeling of warmth and constriction in the throat, epigastrium or the whole of the body, respiratory catarrh, dyspnea, impaired sexual potency. Fatty degeneration of heart and congestion of lungs and liver have been listed as autopsy findings, but these have not been proved due to chloral.

(b) *Mental manifestations.* Psychic dependence, irritability, moroseness, apathy, depression, euphoria, restlessness, agitation, drowsiness, apprehension, anxiety, nervousness, amnesia, dulled perception and apperception, impaired memory, retention, concentration and judgment, insomnia, seclusiveness, suspicion, paranoid reactions, suicidal attempts, impaired libido sexualis.

2. *Acute Chloral Poisoning*

(a) *Physical manifestations.* Drowsiness, unconsciousness, coma, death by respiratory depression or cardiac collapse, obtundation of pain, fall in temperature, pupils usually constricted (may occasionally be dilated, and sometimes do not react to light), reflexes decreased or abolished, cold skin, drenching sweats, fall in blood pressure (blood pressure may be increased), pulse weak and slow, respiration slow, Cheyne-Stokes respiration, cyanosis, jaundice, leukopenia, albuminuria.

3. *Chloral Delirium*

(a) *Physical manifestations.* Fever, sweating. Any of the findings in 1 and 2 may be present.

(b) *Mental manifestations.* (These of course are outstanding in the delirium.) Depression or euphoria, preoccupation, paranoid reactions, fears, apprehension, ideas of reference and influence, feelings of unreality (derealization and depersonalization), disorientation, confusion, impaired insight, lucid intervals, hallucinations (Lilliputian visual hallucinations have been stressed,[27, 28, 29] although auditory are apparently more common), delusions, illu-

sions, impaired perception and apperception, misidentification, dream states, agitation, calmness, impaired memory, retention, recall, concentration, and judgment, mythomania, suicidal attempts (depressive, hallucinatory, persecutory, or confused).

The differential diagnosis of chloral delirium is quite easy unless other drugs in addition to chloral have been taken by the patient. The anamnesis is much more important than the mental status or the physical examination in correctly diagnosing the condition. Exogenous toxic deliria due to other drugs, alcohol and organic central nervous system disorders, e. g., general paresis, must be considered above all other possibilities. There are other illnesses which might simulate chloral delirium, e. g., febrile toxic deliria, uremia, non-organic paranoidal states, schizophrenia, affective psychoses, psychoneuroses, endocrinopathies, e. g., psychosis with Addison's disease, hypovitaminoses, e. g., pellagra, etc.

D. Pharmacology and Toxocology of Chloral Hydrate

Chloral hydrate, $CCl_3CH(OH)_2$, is a colorless, transparent crystalline solid, with an aromatic, penetrating odor and a bitter, pungent taste. It is very hygroscopic, and is made up in water prescriptions, because with alcohol it is said to have a synergistic effect, which is particularly hypnotic. Apparently the old idea that this increased hypnotic effect is due to the formation and action of chloral alcoholate is no longer held.[31] Chloral and alcohol combinations have long been used in the underworld as "knock-out drops" or "Mickey-Finns."

The B. P. dose of chloral hydrate is grains 5 to 20, the U. S. P., grains 10. Great individual variations exist as to the amount tolerated by human beings. Goodman and Gilman[32] give the toxic dose for adults as approximately 10 grams. It has been stated that a dose of grains 30 has caused death in an adult,[26] that a patient taking grains 595 in one dose has recovered,[33] and that in susceptible persons grains 10 to 15 have produced toxic symptoms.[33] Rossetti was reported to have taken as much as grains 50 to 180 per day. He often took alcohol, opium, or morphine along with this excessive amount of chloral hydrate. The reader is referred to textbooks for further details about pharmacology and acute chloral poisoning[34, 32] and for the medico-legal aspects of suicide and homicide with chloral.[26]

Chloral hydrate is readily absorbed from the gastro-intestinal tract. It was long believed that the drug was reduced to trichlorethyl alcohol, CCl_3CH_2OH, a potent hypnotic, which combined in the liver with glycuronic acid to form trichlorethylglycuronic (urochloralic) acid, which was not hypnotic and was excreted in the urine. This reduction to trichlorethyl alcohol has been recently questioned.[85] The urine of patients receiving chloral hydrate may give a false positive reduction test for sugar.

There are conflicting statements in the literature about the action of chloral hydrate on the heart. In the late nineteenth and early twentieth centuries, chloral hydrate was held to be contraindicated by most authorities in cases of cardiac disease but today this view is doubted. It is usually conceded that chloral hydrate induces central vasomotor depression and peripheral vasodilatation. This and muscular inactivity may cause the blood pressure to fall slightly.[23] Glaus[86] reported a series of cardiovascular cases that he sedated with chloral hydrate and saw no need for caution, even in congestive failure. Goodman and Gilman[22] stated, "The belief that chloral hydrate depresses the heart is largely erroneous. While it is true that the drug may cause cardiac depression as can many of the halogenated hydrocarbons, there is no good clinical evidence of any deleterious effect on the heart from the continued use of therapeutic doses." Alstead[87] wrote, "Chloral hydrate in therapeutic doses has no harmful effect on the heart. When the blood pressure is lowered during chloral hydrate administration the effect is not much greater than occurs in natural sleep." He felt tolerance and habit formation was almost entirely absent, a view which obviously is erroneous.

Price[88] noted, "This drug has the reputation of being a dangerous remedy in heart disease, especially in chronic myocardial disease but I have used it very extensively and have never found this to be the case." In Cushny's textbook,[24] it is stated, "The heart is slower after chloral in moderate doses but scarcely more so than in natural sleep. There is often some flushing of the face and head from some obscure central action but the blood pressure is little affected in the therapeutic use of the drug. In poisoning, the blood pressure is reduced by weakness of the vasomotor center and of the heart, the latter manifesting itself also on slowing of the pulse. The action on the circulation from poisonous doses is more in evidence under chloral than under the other hypnotics which do not

contain chlorine. The same difference is met with in ether and in chloroform, of which the latter affects the circulation more strongly. The action on the heart in chloral poisoning resembles that of chloroform, the auricles being affected sooner than the ventricles and the strength of contraction failing more than the rate."

The Council on Pharmacy and Chemistry of the American Medical Association reported,[39] "It [chloral hydrate] should not be used when there is degeneration of the heart muscle. In other cases of heart disease and in arteriosclerosis, it may be given cautiously." Another authority[26] stated, "Chloral hydrate cannot be considered in itself to have a high degree of toxicity, but in diseased conditions of the heart it is a dangerous drug. . . . It appears to exert a depressing action on the heart and in cases of heart disease it may thus cause rapid death. It is probable that it acts in what might be called a test-manner on the heart, quickly affecting an unhealthy one and leaving a healthy one unaffected."

The main effect of chloral hydrate on the human body is its depression of brain function. The drug apparently acts first on the cerebral cortex, then on subcortical structures in a descending manner, finally impairing the vasomotor and respiratory centers in the medulla.

A word might be added about the addiction seen in people who take chloral hydrate regularly. In brief, considering addiction as consisting of relative quantities of habituation, tolerance, and physical dependence, it seems that chloralism consists mainly of habituation, or psychic dependence. Whether tolerance and physical dependence (with withdrawal leading to an abstinence syndrome) exist in chloralism cannot be stated from the information available in the literature. There have been no systematic investigations of exactly what constitutes the addiction picture in chloralism. One would conclude from assessing the writer's patient G. C. that he manifested habituation and probably tolerance. Whether his paranoid delirium was due to intoxication by an excessive amount of drug or to withdrawal cannot be stated. The episode of restlessness, sleeplessness, and depression in July 1946 may have been symptomatic of barbiturate withdrawal.

E. Summary and Conclusions

A case has been presented of habituation to chloral hydrate in a perfectionistic, conscientious, anxious, well-educated, intelligent

man, who by no means, however, could be labelled as a neurotic or as a person with character disorder. Before he developed a physical illness—three years prior to being seen at a time when he had a coronary infarction and a chloral hydrate psychosis—the patient had been a well-to-do, ambitious man, happy and contented in his adjustment to life. He then had a coronary episode, and after suggestions of his physicians, became a virtual invalid. Drugs were used in unnecessarily heavy dosages in his treatment; and, as a result, the patient developed an unrecognized condition, that of chronic chloralism. He began to require more and more chloral to combat insomnia, which actually was a symptom of his chronic intoxication, and finally took sufficient drug to develop a toxic delirium. The content of his delirium, his delusions, hallucinations and illusions, and his Rorschach descriptions, could be correlated with past or present environmental happenings. The prominence in his delusions of auditory illusions was outstanding. Interesting too was the fact that his psychotic beliefs were most prominent at night, after meals, during fatigue, or after emotionally-charged situations.

The historical, pharmacological, and clinical aspects of chloral intoxication, with particular emphasis on chloral delirium, have been discussed with reference to the literature.

It is urged that physicians do not lose sight of the ill effects of long continued and indiscriminate use of sedative and hypnotic drugs. It is also to be emphasized that thoughtless iatrogenic suggestions to patients may be the root of considerable mental and physical distress. The case presented is a glaring example of poor medical management which led to a useful member of society into unnecessary invalidism.

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PSYCHOLOGICAL FACTORS IN SHOCK THERAPY

BY HARRY GERSHMAN, M. D.

In 1937 Sakel described for the first time a series of cases that were treated by insulin shock therapy with satisfying results. Since that time many thousands of patients have received treatment in a manner closely identified with Sakel's original technique. Subsequently, electric shock therapy was introduced by Cerletti and Bini in 1938. The rationale of shock therapy has remained obscure. The organic basis was originally emphasized by Sakel, however; and this orientation has continued.

In the words of Sakel, "It seems that the hypoglycemia had disconnected the most recent pathways and isolated the short circuits and thus prevented the false discharge of reactions from appropriate pathways to inappropriate pathways. After further manipulation of the hypoglycemic treatment it was possible to blockade and isolate the short-circuited pathways so that finally the reaction to stimuli traveled exclusively over appropriate pathways." In another part of the same paper he states, "One cannot escape the impression that each hypoglycemic period serves to remove another portion of the psychosis so that the normal personality can be more and more readily revived."

The prevailing opinion among present-day psychiatrists is that shock therapy works primarily through the physiological changes that are instituted by either insulin or electric shock. It is the present writer's impression that not enough emphasis has been placed upon the psychological reactions to this form of therapy. The writer believes that insufficient attention has been focused on the personality reaction to this violent, and physiological, change encountered in shock therapy. Yet more information can be obtained by placing emphasis on the personality structure of the patient rather than on the nature of the physiological change. This is partly confirmed by clinical experience with respect to correlations of number and degree of comas and improvement. Thus, there are instances where deep comas are ineffective and where very light and few superficial comas are quite effective. More emphasis must be placed on what this particular violent experience means to the patient. The treatment is an emotional experience associated with physiological changes. What the patient does with

this experience may depend more upon him as a psychological, rather than as a physiological organism.

The explanation as to why shock therapy apparently causes improvement in psychotics will depend in a large measure upon our orientation to mental illness proper. We have inherited many years of organic orientation in which mental aberrations are seen as a reflection of physiological pathology. These attitudes prevail in us to a large extent and most of us have difficulty in disregarding these concepts for purely psychological ones. In fact many have pointed to the efficacy of shock therapy as proof that mental illness is due to obscure physiological processes, the nature of which, are in some measure affected by either electric, metrazol or insulin shock therapy.

Of all the illnesses that man is subject to, mental illness is the one most often created by human relationships. Human personality is molded by other human beings. The importance of these inter-relationships have been pointed out very clearly by Harry Stack Sullivan. The molding of human personality is effected by external interpersonal relationships which are ultimately assimilated and integrated within the individual. Eventually, intrapsychic dynamics are established which are in equilibrium with the individual's interpersonal relationships. The nature of the intrapsychic dynamics was first elaborated by Freud. Because of Freud's genetic, mechanistic and instinctive orientation, his libido theory, which was a logical development, led him into blind alleys in the explanation of human motivation. Horney, building upon the foundation of Freud's monumental work, has to date, given us a more dynamic dialectic and holistic approach to the understanding of human personality.

Neurotic behavior results from the simultaneous operation of contradictory drives. Conflict is the basis for neurotic behavior. Psychotic behavior, the writer feels, is a more advanced stage of a conflictual situation within the personality. That this conflict may be at a deep level and appear on the surface in the form of far-removed symptoms is well known. The occurrence of a psychosis in an individual speaks for a very serious underlying disorganization that probably dates back to his most early formative years. That such a person did not previously disclose psychotic behavior was a result of certain defenses which the patient spontaneously created. When such defenses break down, the re-

sulting anxiety may cause the patient to distort reality and live in a world of his own. In a sense this is a defense mechanism too. The appearance of a psychosis is an expression of increased insecurity and anxiety.

That shock therapy can produce remissions is clear. The mode of operation may be in the direction of making the patient more secure and safe. When the patient feels more secure and safe, his need for flight into unreality disappears or diminishes, and he dares to come back to reality. It is difficult to say how shock therapy, which in many instances is a violent experience, can serve to reassure and strengthen the defenses of a personality. In many cases, however, where improvement takes place, this is actually the case. The question we may now ask is not, "What does shock therapy do to the brain?" but, "What does the shock therapy experience mean to the patient?"

If we can look upon mental illness as primarily a psychological disorganization, then the value of shock therapy must be interpreted in the light of these psychological implications in the treatment. We know from past experience that various forms of organic therapy have improved psychological illnesses. It is well known that probably half of general practitioners' cases are psychogenic. Every clinician, who has had experience in a state hospital, has seen the improvement of mental illness during a siege of physical disease. In the past history of the treatment of mental illness, we have gone through the varying phases of apparently effective transient treatment by removal of intestines, gall bladders, stomachs and, more recently, brain tissue. The improvement first observed in psychotics who had malaria was recognized and led to the malaria treatment for general paretics. All these varying physical approaches to the treatment of mental illness have at one time or another claimed transient but definite improvement. Now, we are in the era of electric shock, metrazol and lobotomy. If it is true, and there is no reason to suppose that it is not true, that improvement has occurred from all these varying types of approaches, we might ask ourselves what is the common denominator in all these widely varying procedures. It would seem to the writer that the common denominator is the human relationship which, explicitly or implicitly, plays a prominent role in the therapy of impaired interpersonal relationships.

One of the most frequent symptoms of psychotics is lack of insight. Invariably the psychotic patient will deny that there is anything wrong with him but will externalize all his difficulties, be they his wife, his job, money, voices, etc. This self-blinding is of course a defense against acknowledging the terrific conflicts in operation. By externalizing their difficulties the mentally ill spare themselves the direct assault on themselves, and, in fact, become innocent victims of plots against them by the outside world. Thus the safeguarding of the self is of tremendous importance; when this safety defense mechanism is not in operation we see the pitiful state exemplified by the agitated depression. These agitated and depressed people feel the full brunt of their self-hatred as is shown by guilt feelings, self-depreciation, self-belittlement, and so on; and they can only obtain a solution in suicide or suicidal attitudes. When one contrasts this clinical picture to the relative well-being of the paranoiac, one sees the tremendous value of the paranoid defense mechanism. In the latter, most of the assaults upon the self are externalized.

Now what are some of the psychological factors that play a part in shock therapy? These factors may be considered external and internal. Let us consider the internal factors first. We know that in psychotics the real self is weak, impotent and ineffective. It had managed to survive by creating in its imagination an unrealistic, inflated, grandiose image of the self. As long as the individual has that idealized image, no conflict ensues. But the basis of this grandiosity is real to him, and he makes a series of claims upon his environment. Thus, living in imagination when exposed to reality, the fraud becomes apparent, and the real self with all its weakness is disclosed. Such a person at that time has a deep sense of hopelessness, helplessness and pessimism. The fact that something is being done for him, and that human beings are doing it, is a major factor that diminishes his self-destructiveness. This may be considered a supportive form of therapy, much more implicit than explicit, which the patient senses and reacts to, even though his overt behavior and conversation may be quite to the contrary.

The feelings of guilt that are so often in the foreground may stem in part from a patient's real dereliction in responsibility but more often come from rage against the self for not having lived up to the idealized image that the patient has created in his mind.

Sometimes this intense feeling of guilt comes in the form of a need for punishment which is mitigated by the patient's misinterpretation of shock treatment as a form of punishment. Guilt is often appeased by the realistic observation on the part of the patient that he is ill and weak. Guilt is also frequently mitigated by the realization on the part of the patient of his real helplessness.

We know that in many severe mental aberrations the breakdown is due in no small measure to the excessive demands which the patient places upon himself. By hospitalizing him and giving him treatment, we, in effect, remove some of this responsibility. By treating him, we imply that his illness is not solely his responsibility, and that fact, in itself, can be of profound help to the patient. True, this is a neurotic solution to a difficult and complex problem, for the patient can only recover when, and if, he assumes full responsibility for his life. Nevertheless, if we conceive of this as a dynamic process where timing and spacing is so important, a little help at the propitious time can start a person on the road to recovery. In the last analysis all those cases that recover or improve do so as a result of their own underlying constructive forces.

Patients who are psychotic live a great deal in their imaginations. Very often their real fear of a mental hospital is magnified in tremendous proportion—to a degree where that fear itself becomes unreal. When they finally come to grips with the situation in the hospital, the unrealistic fear often diminishes and the patient feels better for that reason. Many psychotic trends are of an excessive, compulsive nature which fatigue and exhaust the patient. Shock therapy serves to interrupt such compulsive thinking by inadvertently confusing the patient and causing him to lose his memory. That brief lapse of time may be sufficient for the patient to mobilize his constructive forces unconsciously and start the way to recovery.

Psychotic patients are as a rule far removed from their real selves. They are alienated from their feelings, and as a result, feel emotionally dead. The intense stimulation resulting from shock therapy in many instances restores the patient's feeling of being alive, although in a very amorphous fashion. The fact that they can feel again is often sufficient to restore partial faith in themselves.

A word can also be said about the patient's going in and out of coma. Many emotions that have been repressed are allowed to come to the surface during this time and patients often have a "good feeling" following insulin coma reaction, similar to that "good feeling" that is often experienced following a dream. It is not the insulin that is specific—but the insulin coma experience that is important. This experience has a unique meaning to the patient.

Some of the external factors that operate in the recovery of a patient stem from the supportive forces in the therapeutic situation as reflected in the atmosphere and morale of the ward. Patients have repeatedly expressed their gratitude for a judicious word of encouragement at the proper time. This helpful attitude on the ward need not be one of excessive, demonstrative affection and oversolicitous concern. Most patients can discern sincerity in the environment. All these factors in the environment, namely, the doctor, the nurse, and the staff, are simple expressions of human help which are undoubtedly of great aid to the patient. As has been noted, mental illness is a peculiarly human disease born out of pathological human relationships and can only be arrested or cured by wholesome human relationships which can be assimilated and integrated in the personality. The fact that there are other human beings interested in him is of extreme value in the patient's recovery. One sees, of course, time and again how patients project their own hostility to themselves onto their environment. The hospital is often seen as a prison, and the doctor as a cruel warden. This projection stems from, and makes for, intense isolation and loneliness which can only be relieved by sincere *sustained*, genuine helpfulness on the part of the environment. Other non-specific external factors that are also important are longer periods of rest, gain in weight, and extracurricular activities which are offered to the patients and help recovery.

The writer has just elaborated a very sketchy, superficial outline of some of the psychological factors, both internal and external, that play a part in the shock therapy situation. He has attempted to underscore the importance of the dynamic factors within the personality. These factors in the last analysis determine whether the patient is to get well, and whether he will get well for longer or shorter periods. We can see that where the personality is not deeply involved, where little distortion of reality has taken place,

the response to therapy may be more prompt and the prognosis better. Clinically, we see that in depressions of recent origin, particularly where the depression is of exogenous origin; where the psychological disorganization is on a deep level and is characterized by a good deal of reality distortion, as seen in schizophrenics, a longer and more intensive interpersonal relationship than usual is necessary. The writer believes that explains, in part, why insulin shock therapy has been uniformly better than electric shock therapy for such people. The human contact is longer in time per session as well as in the number of treatment days. This also explains why we uniformly achieve so little improvement in patients who have been ill a long time, particularly on chronic services. Their remoteness from other human beings is so great and permanent that no approach to them is feasible.

The question can be raised whether electric or insulin shock therapy, with the concomitant physiological changes, is necessary for the recovery of patients. Could we not accomplish the same by intensive psychotherapy? It would seem to the writer that where we can rely on psychotherapy alone, such procedure is preferable. In situations where rapport cannot be established, where the patient is too disturbed and destructive, shock therapy is indicated. It would seem further that electric and insulin shock therapy set the stage for mobilization of the patient's rapport with the doctor. This treatment makes the patient more helpless and defenseless in many ways; but, by the same token, the ensuing human help that is given is likewise greatly magnified. The point is that shock therapy initiates specific physiological changes to which psychological reactions occur, which set the stage for the mobilization of the constructive forces in the personality. Shock therapy has different meanings for different patients, and patients get well for different reasons which are peculiarly their own.

Shock therapy, even where it is effective, may be considered as a form of treatment in which symptoms are removed. We know from clinical experience that the mere removal of symptoms is not sufficient, for other symptoms appear in their place. Furthermore, symptoms may be removed without touching the underlying psychotic character structure. In the treatment of psychotics with shock therapy we remove symptoms, namely, the distortion of reality, the destructiveness, the reaction to auditory and visual hallu-

cinations. That symptoms may be removed without any real alteration of underlying character structure is seen in the way these patients resort to psychotic defenses under duress. The question may then be raised, "Is it worthwhile to remove the psychotic symptoms by means of shock therapy?" The answer as based on experience in the state hospitals would certainly be "Yes." Although this symptom-removal is superficial, incomplete and inadequate, and often subject to periodic relapses; nevertheless, in many cases, this temporary break affords the patient sufficient time to mobilize that which is constructive in him. This temporary respite is often sufficient to permit the patient to begin to work on himself. On the other hand, this approach has many drawbacks. By instituting shock therapy we often play into the hands of the patient's mental illness by recognizing that he is suffering from an illness which we are treating symptomatically, rather than working on the underlying personality defects. Most patients are all too ready to accept the concept that they are suffering from an illness for which they have no responsibility. Treating them with shock therapy is a tacit confirmation of the patient's need to externalize this illness.

The writer would like to repeat that the manner in which shock therapy works is not clearly understood. It is his impression that sufficient emphasis has not been placed upon the psychological factors implicit in this form of therapy. He believes that the effectiveness lies in the personality reaction to these violent physiological changes *per se*. Perhaps more information can be obtained by placing emphasis on the personality structure of the patient than only upon the nature of physiological changes. Too much emphasis has been placed on the degree of physiological change and not enough on what this particular experience means to the patient. The treatment is a strong emotional experience and what the patient does with it depends on him rather than on the experience. We should remember—we are not treating abstract illness, but human beings with problems.

Summary

The psychological factors, implicit and explicit, in shock therapy are discussed and stressed. Shock therapy is considered an emotional experience to which the patient is exposed. This experience has unique significance for each patient. Whether he uses this ex-

perience destructively or constructively will depend upon his character structure. Human personality is discussed as a dynamic psychological structure which can only respond to psychological stimuli. Physiological concomitants of shock therapy are not considered the important factors contributing to the recovery or relapse of the patient. Emphasis is placed on the emotional response to the shock therapy experience.

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A STUDY OF THE MENTAL STATUS OF SCHIZOPHRENICS HOSPITALIZED FOR OVER 25 YEARS INTO THEIR SENIUM

BY MORRIS D. RIEMER, M. D.

One observes, in the course of mental disturbances, various phases of illness. The neuroses have sudden exacerbations, extreme fluctuations of mood, different types of activity or inactivity and increases or decreases in anxiety. The manic-depressive psychoses display cyclic changes and periods of apparent recovery and quiescence. Dementia præcox presents characteristic episodes and intervals in the psychic picture and behavior pattern. The organic psychoses also appear in prodromal, active and convalescent stages; this is particularly evident in general paresis, in the senile and in the alcoholic psychoses.

Since shock treatment has been in use, the usual phases of the cyclic schizophrenic illnesses have changed considerably. An attack is thereby abruptly interrupted, with apparent subsidence of the acute symptoms. To some, it has seemed that regression is much more marked than formerly in any recurrent attacks. Hypochrondriacal complaints appear oftener.

A large percentage of today's patients leave the hospital after they have overcome their acute psychotic attacks—they may remain on the outside for a varying period of years and return from time to time when they have recurrent episodes. Another group of patients, because of intercurrent infection, injury, age, suicidal acts or poor physical condition, die in the hospital or at home. Finally, there is a considerable number of patients whose illnesses become chronic, necessitating continued institutionalization.

This last group is the subject of the present study, which is confined to schizophrenics who have remained in the hospital for over 25 years without leaving at any time, so that they have been available for continuous check-up. Despite the fact that the clinical picture changes but little in these patients, the inspection of the total period of hospitalization and the progression of the disease during that time are most interesting. There is, for one thing, an opportunity to determine whether their schizophrenic psychoses are superseded by senile or other organic mental disturbances.

This survey involves the study of 100 schizophrenics. Equal numbers of each sex were selected. These patients have been at

Brooklyn State Hospital continuously for over 25 years and have reached the senile period. All are more than 65 years of age.

These patients were examined carefully to determine the mental picture they presented after this long hospitalization, and to find whether any specific or gross changes had taken place. For this purpose, follow-up studies during many years past, and case records and notes were correlated with the current clinical picture.

Sixty-five per cent of these individuals who showed delusional ideas at the time of hospital admission continued to entertain their abnormal mental content throughout the hospital residence, and at the time of their last interviews, displayed but little change in their attitudes, emotional reactions and ideational responses. Of this large group, none evinces any sensorial impairment.

About one-half of the 100 patients had originally been diagnosed paranoid dementia præcox, and had shown the characteristic, well-preserved personality of this disorder. After 25 years or more of hospital residence, they show the same facade of hostility and paranoid aggression in their manner and behavior. The well-preserved personality has remained throughout the many years of their hospital residences. They, likewise, retain their whole retinue of systematized and unsystematized delusional formations.

Twenty per cent of the entire group, upon study, appear to have shown signs of severe regression immediately after hospital admission; another 10 per cent did not display this until a few years afterward. It is to be noted therefore, that although regression should not be confused with deterioration, the former appeared within a short time after admission and not during the senium.

Most careful testing of the sensorial state of all of these patients reveals no outstanding memory or other sensorial impairment. The sensorial state of the regressed patients is naturally most difficult to determine and may appear to be defective. The defective sensorium, however, is not the characteristic one observed in the senile period; that is, the patients do not show impairment of recent memory and a relatively well-preserved remote memory. The difficulty with these schizophrenic patients in their sensorial responses is one of preoccupation.

Careful study of all these patients does not reveal any evidence of the typical childishness of the senile patient nor is the emotional instability and lability of the arteriosclerotic seen.[1] Other features usually found in the senile psychoses, such as excessive hoarding,

or ideas of neglect, are not present in these patients.[2] Clinical signs of localized cerebral lesions are also absent. These patients do not present the marked suggestibility and fabrication of some seniles.

From these findings, it appears that the long-hospitalized schizophrenic individual is not predisposed to develop a senile psychosis. The invariable conclusion from study of this group is drawn therefore, that dementia præcox in chronic, hospitalized patients appears to be an end result in itself and does not metamorphose into another phase of mental illness, such as a senile psychosis. If these findings are correct, and these individuals do not develop senile psychoses, it would seem ironically enough that chronic dementia præcox, therefore, is a hedge against an organic psychosis. One must, however, ask why this type of patient remains apparently invulnerable to an organic psychosis.

It is well known that there is a so-called presenile personality despite the fact that organic brain changes are found in every senile psychosis. There is evidence that psychic factors play an important role in this type of psychosis.[3] Yet, from the foregoing, it would seem that, on the contrary, long-standing schizophrenia does not predispose the individual to an organic psychosis. This is borne out by the cases studied herein. They revealed no evidence of organic changes; and their schizophrenia apparently preserved these patients from organic psychoses.

These clinical findings speak for an apparently low incidence of cerebral arteriosclerosis and senile brain changes in long-hospitalized schizophrenics. If metabolic phenomena or pure vascular pathology is, in great part, responsible for the organic brain diseases, then why is there such a low or diminished frequency of organic changes in this particular group of patients? The prolonged and chronic disease process of schizophrenia indicates perhaps that vital forces have found an outlet in gross psychic changes and apparently require no further medium upon which to wreak pathological effects. This is not entirely true of the schizophrenics who are able to leave the hospital for long periods of time. The anamneses of senile psychotics often reveal that patients have had previous attacks of mental disturbances and have required hospitalization for short periods of time. Histories of patients showing clear-cut, senile mental disturbances give frequent records of previous mental attacks of a schizophrenic nature which occurred in the presenile years or in early adolescence or adulthood,

with resolution of the attacks and subsequent return to previous states of mental health. The point which is particularly emphasized in this paper is the absence of clear intervals in the histories of the 100 schizophrenic patients studied here, and the presence, on the contrary, of continuous, unabating, schizophrenic illnesses. This is in contradistinction to the reports of psychotic exacerbations followed by quiescent periods which are found in the anamneses of many patients with senile and arteriosclerotic illnesses. It is important in this study to differentiate between the long-hospitalized schizophrenic and the one who is able to get along outside the hospital for varying periods.

Again we find in the history of patients developing senile psychoses that they frequently show many pathological traits in their make-ups. In contrast to the well-known prodromal signs of schizophrenia, those most frequently shown before the outbreak of senile psychoses are such abnormal characteristics as stubbornness, tendencies to dominate, grimness and tenacity, inclinations to exaggerate, and rigid conformity of reactions, with lack of pliability in almost all situations. Prodromal senile psychotics also regularly manifest greater insecurity and no doubt meet the stress and strain of life with an inadequate characterological equipment. While they are apparently able to hold out, with integrity of psychic economy, up to the sixth or seventh decade of life, the ensuing disability and illness of the senile psychoses, speak in no small part for the underlying pathology and mounting damage that has been going on throughout these patients' lives.

The indications of the foregoing study are that intense anxiety seeks expression at all times. If it can express itself through a constant and well-integrated psychotic and delusional program, then the anxiety forces seem to have an outlet. On the other hand, if these forces continue to be submerged, they find egress in many directions, many of which may assist in the production of the senile psychotic state.

Summary

1. The incidence of senile psychoses in chronic hospitalized schizophrenics is negligible.

2. It is concluded from study of the anamneses of senile psychotics that schizophrenics who make adequate adjustments, enabling them to leave the hospital, and who can remain in the com-

munity for long periods, are much more prone to develop senile psychoses than are chronically-hospitalized schizophrenics.

3. The stress and strain of reality, one is led to infer, meeting the rigid and inflexible equipment of the damaged psyche of the schizophrenic during intervals outside the hospital, provokes a further breakdown of the organic systemic and brain structure.

4. The chronically-hospitalized schizophrenic is spared the responsibility of coping with reality and thus spared a consequent strain upon his systemic organization.

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EXPERIENCES IN GROUP PSYCHOTHERAPY WITH INSULIN-TREATED PATIENTS*

BY HERBERT B. WENDER, M. D.

In recent years group psychotherapy has made tremendous advances and today is being employed with psychotic patients.[1, 2] Many of the older workers in the field have made serious objections for various reasons to its use with psychotics; but the limited number of physicians in state hospitals, faced with an ever-increasing admission rate of patients, must seek technics which will assure adequate psychotherapy for each patient. In June 1947 a group psychotherapy project was begun at Brooklyn (New York) State Hospital. Various groups were started, one of which was on the male insulin service, and to which the rest of this report will be confined. The other aspects of the project have been reported upon elsewhere.

The present writer organized the group on the male insulin service in August 1947. Seven patients then receiving insulin coma treatments were questioned regarding their willingness to participate in group sessions twice weekly. These seven were selected as a nucleus for two reasons: They had only recently commenced treatment and they were considered to be in fairly good contact. All agreed to participate. This was the only time patients were asked to join; thereafter, all additional patients entering the group requested to participate, and none were excluded unless it was felt that they would hinder the group because they were too severely disturbed at the time.

At this point it is important to mention that the male insulin service is a compact unit, made up of 30 to 35 patients, all diagnosed schizophrenia. The patients live together on the same ward. They eat together, receive treatment together, and perform various activities together. The personnel is fairly permanent. The only temporary personnel are student nurses who come for definite periods as part of their training.

The patients are received at various times and begin treatment at different intervals. It would frequently occur that, on first admission to the ward, patients would be too severely disturbed to

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participate in the group program and would not join until several weeks of treatment had passed. Also, as patients completed treatment and were allowed to go home, new ones would be admitted to the service and would then join the group. Thus, during the eight months of this group program a total of 57 patients participated. Fifty-two sessions were held, each lasting an average of one and a half hours.

Since there was no exclusion of patients expressing a desire to participate, the number at a session varied and actually went beyond the number that was originally intended. For reasons to be enumerated later, it was felt that it was better to allow this than to exclude suitable patients. As a result of this method, the number of men attending the sessions varied from seven, at the beginning of the group program to 18 on occasions. In the last four months, there were rarely fewer than 12 at a session.

A course of insulin shock therapy usually takes 10 weeks for an average total of 60 treatments. Frequently patients are too disturbed during the first two weeks for group therapy. Hence, most of the patients attended sessions twice weekly for eight weeks, making an average of 16 sessions for each patient.

The sessions were conducted in the dormitory of the ward, which is also used for the insulin coma treatments. Beds and chairs were arranged in semi-circle around a desk at which the therapist sat. The atmosphere was informal and the patients were allowed to smoke. At the first meeting they were told: "This is your group. You can discuss here anything you wish. Although I am here to help, it is more important that the discussion come from you."

At the beginning, a single attendant was assigned regularly to the group, as it was uncertain what the patients' reactions would be. The reaction was good; thereafter, attendants and nurses kept a record as to when it was each one's turn to sit in at the group sessions—and deemed it a privilege to be there. Although they took no formal active part in the sessions, they would occasionally be brought into the discussion by members of the group and then would participate. It was at first thought that the presence of such outsiders would hinder therapy and impede progress, but it was soon found that "visitors" had little effect upon the material brought up by the patients. There were, on occasion, other visitors to the group sessions, two of whom were women graduate

psychology students. Although they sat in on several occasions, it soon became evident that their presence made no difference in the nature of the material discussed, even though this was frequently sexual.

Progress and Material in the Group

During the first few sessions, the patients kept asking questions about insulin shock therapy, its purpose, its effect, and, "When will I be allowed to go home?" These questions were answered, in order to orient the patients as to the therapy they were receiving. It was noted, however, that the questions came up with every new patient entering the group, requiring the therapist to answer, and thus keeping group participation at a minimum. The problem thus raised was put to the group for consideration. After some discussion, it was decided to eliminate all such questions, with the understanding that the older participants would orient the newcomers on those points outside the session. As to orientation concerning the group therapy itself, it was also found best to turn the orientation of the new patients over to the group members. This was the method maintained thereafter. It was felt that this allowed for a greater latitude in the discussion of subjects which were all introduced by the group itself. It is noteworthy that sexual material did not come up until the group was fairly well established.

One of the first subjects discussed by the group was the attitude of people in general toward those who had been patients in mental hospitals. That this was brought up so soon is an interesting point in terms of how we think about patients facing the outside world. In other words, they asked, "What will be the attitude of people on the outside toward us when we get out of here?" This question came up repeatedly here—and later in an out-patient group. The patients decided that it would take much education of the public to alter its attitude toward mental patients.

Soon thereafter, as the patients became more confident in the group, more certain of the accepting role of the therapist and more sure of themselves in terms of the hospital and the ward, several so-called "gripe sessions" were held. At these they aired all their complaints regarding the activities of the ward, the division of labor in terms of patients, and some of their ideas as to how the ward program of activities could be bettered. As a result of sev-

eral such sessions, they organized a sort of committee to help with the ward work and to see that it was equally divided if possible. This fostered, as well, a definite group spirit and feeling which can be related somewhat to team spirit in school. The patients also, of course, complained about various administrative difficulties and, occasionally, about the personal attitudes of attendants and nurses—complaints which were often part of projection mechanisms, for many of the patients were paranoid. Where their complaints were justified, adjustments were made, through administrative methods where possible, or by discussion in the group. After several such sessions it was noted by both nursing and attendant personnel that the ward functioned more smoothly than previously. As an aside, it should be mentioned that for at least the latter half of the period when the group sessions were active, there was only one patient who required restraint. This was unusual and may be coincidental, although ordinarily there had been several disturbed patients on this insulin service requiring some form of restraint.

The group, by this time, had established a definite group attitude and group feeling. An incident occurred which proved this point. The patients were invited to a party at a time which conflicted with the group session. They were allowed to decide what they wanted to do. Eleven of the 14 patients who were in the group at that time preferred to have the group session. In a very definite sense, the group had made a transference relationship to the therapist as a very accepting individual; and the members were now able to bring forth some of the conflicts and other material which in two cases, at least, had been held back from individual interviewers.

In one case the patient, diagnosed as a catatonic schizophrenic, had come to the hospital in a state of excitement, severely disturbed, incontinent of urine and feces and requiring considerable sedation and restraint. On his admission to the insulin ward, he was still in this disturbed state and was almost immediately started on treatment. Following about 10 days of insulin treatments, he improved sufficiently to request admission to the group. After sitting quietly for several sessions, he expressed a desire to talk about himself and thereafter occupied almost half of one session talking about his catatonic excitement period. This patient had a history of divorced parents, with rejection by both his parents.

He had been brought up by a grandmother to whom he was tremendously attached. He was married, had one child and his wife was again pregnant. He was a chemist and had earned a satisfactory livelihood. He had one sibling, a sister of whom he was jealous, as his mother had paid considerable attention to her. His psychotic episode had been of acute onset. During the group session he proceeded to elaborate his ideas and reactions during that time. He said that he felt he was a three-year-old boy named Billy (his own name was Charles); and, as he was Billy, he, of course, could not recognize his mother, his grandmother or wife when they came to visit him. He also said that, as he was only three years old, he obviously had no control over his bladder and bowels and therefore would eliminate wherever he was. He expressed the idea that during this period, since he was such an infant, he wanted to get attention. His obvious rejection of all the female figures in his life at this time was because he had not received satisfying attention during the period to which he was now returning. He went into further material bearing upon this excited stage and explaining why he had to do the various things he did. Toward the end of this recital he had a tremendous abreaction, broke into tears and asked to be excused. He returned to all the following sessions, however, and it was interesting to observe how concerned the rest of the patients were for his welfare and how they attempted to cheer him up and to make him forget this unpleasant experience. After he had left on that occasion, the group discussed what he had related and attempted to work out several of the dynamic factors mentioned. Subsequently, this patient left the hospital in improved condition. After his return home, his wife separated from him and is now seeking a divorce. Although on several occasions he has been tremendously depressed and upset by this, he has continued to make an adequate adjustment and attends the out-patient group psychotherapy sessions which the writer is conducting at present.

The writer thinks it would be helpful to relate another case, that of a patient of Italian extraction, about 32 years old, who came to the hospital because of a severe excited episode. When he came to the insulin service, he was somewhat retarded and withdrawn but no abnormal mental material could be elicited. In fact, at that time it was felt that there was a possibility that his diagnosis was in error, that this patient might be an epileptic, and

that the acute psychomotor activities related in the history were epileptic equivalents. However, an EEG at that time was negative. Although he was not receiving treatment, he attended the sessions. One day he came to the therapist, requesting a personal interview, which was granted.

At that time, this patient expressed all the delusional and hallucinatory material which he actually had been experiencing for many years, including a period of war service which had lasted for at least three and one-half years. This had never been elicited previously, although he had been examined and interviewed on several occasions. With the diagnosis of schizophrenia now established, this patient was started on insulin treatments. During the further course of his attendance at group meetings, he elaborated considerably on his various hallucinatory experiences and on the delusional material which he had guarded for so long a period. Although he had a marked language difficulty, he explained and elaborated fully on much of this material in the group and was the source of some very fruitful discussions regarding some of the mechanisms of hallucinations. It was interesting to note that on one occasion when this patient spoke of sleeping at night with a knife under his pillow to protect himself against the people whose voices he heard, the group took this up and attempted to explain to him that his fear was in himself and that he was projecting this fear to the outside. This patient also left the hospital in good condition and, although he has not attended the sessions of the out-patient group, he continues to make a good adjustment a year after his return home. These are two examples of many which could be cited equally well.

Some of the further material that was discussed in these group sessions included daydreaming which took up several sessions and which the patients related to some of the hallucinatory experiences mentioned by the previous patient. It is interesting also to note that the patients would make this connection themselves, inasmuch as the therapist would rarely, if ever, give any actual dynamic interpretations, unless it was felt that it would aid the patients in continuing the discussion. The patients also discussed the subject of rejection. This followed the showing of the Canadian Army film *Rejection* and resulted in a good deal of emotional reaction in some of the patients, particularly in those who had come from homes broken either by divorce or death of the parents. At a

later date, when a new patient joined the group and discussed his problem, which included a background of a poor home, several of the patients made reference to this film as, in part, explaining that patient's difficulties. The sexual material which was brought up was concerned mostly with masturbation, marriage and, on several occasions, homosexuality. Inasmuch as many of the patients were paranoid, the subject of homosexuality brought forth very little discussion. In fact, they seemed to "shy away" from the subject, giving the impression that it was fraught with danger to them. At that time, the writer felt that this might be one of the restricting factors in group psychotherapy with psychotic patients, and the subject was not pressed.

It is important to note some of the dynamic factors in this group situation. With many other workers in the field, the writer feels that group therapy helps the patient in his individual therapy. Besides this, however, the group situation contributes beneficial factors not available in individual therapy. This applies in particular to the schizophrenic patient who is ordinarily so alone in his sickness. In group therapy, he soon becomes aware of the fact that there are other people who are in the same boat. This is a marked advance, in and of itself, for the psychotic patient, because in individual therapy this realization is usually not obtained. After the patient has established himself as part of the group, the presence of the group allows him a much freer latitude in discussing his problems. Not only did the therapist get the feeling that the transference reaction was established fairly quickly, but also that it was not only a patient-to-therapist reaction but one of patient-to-patient. This latter transference reaction is something that most psychotic patients fail to achieve in other situations. It is felt that for the psychotic patient this group feeling and group reaction plays a tremendously important role, and that whether the participants really get any emotional insight is relatively unimportant. The other dynamic mechanism is, of course, the accepting parental role of the therapist with group members as siblings.[3] It was early observed that many of these patients could not stand any hostility or rejection—if it was evident in any way—and it is felt that an important part of the role of therapist in group therapy with psychotic patients is to accept, and to avoid any semblance of such rejection.[4]

The insulin set-up in particular lends itself to other developments in terms of the relationship of the patients to the ward personnel. When the ward personnel were questioned regarding their feelings about group sessions, not only did they express their approval, but they stated they felt they understood the patients much better; and, thus, their attitudes toward even disturbed patients could be more lenient and more accepting. In the converse, many of the patients now recognized the personnel as being part of the activity of the ward and not simply people who are there to watch them. The particular set-up of an insulin service such as this lends itself admirably to developing such a mutual understanding. It was for this reason that the attendance of ward personnel was continued after the initial trial; and it is the writer's opinion that this participation is a very important part of group therapy in such a ward set-up. In addition, the ward set-up fostered group interaction and reaction in circumstances far beyond the actual group sessions. Both the ward personnel and the patients themselves told the therapist that discussions would take place in the day hall, and frequently these discussions would be brought to the group meetings and continued there. It is for this reason that the progress made with the insulin groups far outshone that with other groups in the hospital. The writer, therefore, feels that the type of set-up in which the patients in the group live on the same ward and carry on their activities together is best suited for group psychotherapy in hospital.

Role of the Therapist

The present writer feels, with many other group psychotherapists, that a passive role is probably the best one to take.[5, 6] If the therapist becomes too involved in the discussions, his authoritarian presence results in curtailing the active participation of the group. Frequently, the patients attempted to force the therapist to answer questions or to act as a referee. The method of handling this situation was usually to turn the questions back to the group as far as possible. There were, however, occasions when it was necessary for the therapist to give information or some interpretation. The point must again be made that, in dealing with psychotic patients in the group, there is frequently considerable hostility aroused in the therapist by some patients. As has been pointed out by therapists who have treated schizophrenics individ-

ually, this often is a testing of the therapist's attitude, and he must guard himself against any expression of this hostility—which the schizophrenic patient immediately interprets as a rejection."[6,7]

Comment and Conclusions

The results of this group psychotherapy program cannot be evaluated in statistical terms as there are too many variable factors. Rather, the writer would prefer to offer some of his own conclusions which are based on opinions and impressions gained during this period and subsequently. Some of these opinions have already been expressed but for clarity they may be enumerated as follows:

1. Group psychotherapy is a feasible method of treating psychotic patients. It is readily available to fairly large groups of patients and aids the in-hospital adjustment of many of them.

2. It is particularly helpful where the compact ward unit is used, as the group reaction and patient-to-patient relationship is aided and stimulated by the ward set-up where the patients live and perform all activities together.

3. When the compact ward unit is used, it would appear better not to restrict the number of patients attending group sessions but to allow up to 20 to attend. Thus a group will include at least a majority of the "good" patients and prevent the formation of cliques.

4. Since ward personnel are an important factor in ward function, members should also attend sessions. Personnel should, if possible, be permanently assigned to the ward. The group sessions aid a great deal in the attitudes and relationships between patients and personnel.

5. There would appear to be a significant correlation between participation in the group and ultimate prognosis. In the small number of patients reported here, 88 per cent of those most actively participating in the group sessions were allowed to go home from the hospital.

6. A follow-up one year later would appear to indicate that the adjustment outside the hospital of those patients who were in the group, was significantly better than that of those who had not had the advantage of group therapy. This matter would require further study before a more definite conclusion could be reached.

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As a result of the writer's experience with it, he feels that group therapy should be made an integral part of the treatment program of all state hospitals; that this form of therapy should, when possible, be continued throughout the time that the patients are on convalescent status.

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A CASE OF CONJUGAL PSYCHOSIS

BY SAL A. PRINS, M. D.

In Bleuler's *Textbook of Psychiatry* there is a short chapter headed: *"Das Induzierte Irresein (folie à deux)"* meaning, "The Induced Psychosis." Here are a few sentences of this interesting item:

"Sometimes paranoid or paranoia patients (rarely hypomanics) have persons of their immediate environment not only believe their delusions, but they infect them so that they under given circumstances build and elaborate upon the delusion. In any case, they are not able to discriminate the discrepancies with reality. They may have similar falsifications of memory and, eventually, even illusions and hallucinations the same as the first patient, and they may experience also paranoid or hysteriform excitations. In this case the name 'induced insanity' is used. In such cases the primarily ill inducing patient is an energetic character. The induced persons are mostly relatives, more rarely spouses," etc.

The present writer is reporting one of the cases which Bleuler regards as very rare, an induced psychosis by husband upon wife.

The literature about this subject does not provide too great a number of cases of *"folie à deux."* In an odd 110 cases in the English literature, (Gralnick, *"Folie à Deux*—The Psychosis of Association"*) there are 26 in which husband and wife are involved, but only 11 where the husband is the "inductor," the wife the "acceptor" (to use the terminology coined by Coleman). And even among these 11, there is none closely similar to the one added here to the list.** The type of *folie à deux* should be listed in this case as: *folie induite* (induced psychosis) as first described by Lehmann (1885).

The discussion and case histories both demonstrate that the psychosis of the recipient came *only through induction*, as well as the important part played by pre-psychotic personality. Symptoms of the inducer played the role of catalyst to set the psychotic process in movement. A striking feature also was the alternating character: as soon as the recipient took over, the inducer lost his

*PSYCHIATRIC QUARTERLY, 16:2 and 3, April and July 1942.

**Similarity only exists in the three cases described by Babcock (1895), by Rhein (1922) and by Pollack (1937).

symptoms; the same moment the recipient was hospitalized, the inducer, now again by himself and alone, resumed his symptoms.

A patient was admitted to State Hospital South, Blackfoot, Idaho, November 28, 1947, with symptoms of anxiety, fear, apprehension, agitation and disorientation. Mrs. X, the 34-year-old wife of a university professor, had been acting strangely for a few days and after she, finally, had begun to shoot a pistol around the house, she had been taken to the hospital.

On admission, she was highly confused and apprehensive. Her case history reports her mother, 56 years of age, as a little "hysterical." There are no siblings. The father is one of 10 children. One brother is an alcoholic. All are artistic and highly intelligent.

The patient is a good mixer, had "many friends and no enemies." She is "very religious," but not of the church-going type. She "tries to live up to it." As an adolescent she had been shy and had not joined in student activities at the university because of her "heavy working schedule." When she was 19, she married a boy from the university with whom she had been going since the age of 16. She was not "in love" with him and had to support him by her salary as an office worker. After three years, during a greater part of which time they lived separated, they were divorced by mutual agreement. The patient, however, apparently found sexual gratification in her second marriage, which took place four years after her divorce. The second husband is the second patient discussed in the present paper. After the second marriage, the wife continued to work to help support the family, although she had resolved never to support a man again—the second husband had to "work his way up" in the university faculty. This marriage is now the patient's main interest. As an avocation, the patient likes to draw; she does not think she is especially talented at music and so does not practise it actively.

Just before her hospitalization, the patient had become very grieved and apprehensive over her husband while she was visiting her parents. He was in the hospital during that time. She had had no previous mental disturbances. She eats unusually often, sometimes during the night.

Her physical condition, including blood, spinal fluid and urine, appeared to be entirely normal. Neurologically, nothing abnormal was detected.

The mental examination revealed a brilliant-minded, intelligent personality, loaded with persecutory delusions, with hallucinations of which she still does not realize the true character. She appears to have made the wrong solution of an incest complex and to have overcompensated her inferiority feelings—created by the fact that her parents were foreign—in marrying, twice, effeminate men. This, of course, aimed to bring her back to the condition of her parental home with an intellectual, highly-domineering father figure, whom she adored and idolized.

Analytically, it is easy to understand why she twice made her choice of a husband in this special kind of man. Talking about her home and parents, there is practically only the question of her father. Her mother, she never during all the hours of the interview so much as mentions, except in a few kindly but belittling words. She worries about her reaction if she knew of her only child being in an "insane asylum." Her being of partly German descent has been the main cause of the patient's trouble with her schoolmates.

This patient solved her Oedipus complex by identifying herself with the father, her old libidinous object, *as if she had been a boy.* Then she chose husbands in the pattern her mother had. She hates her mother and repeats this in hating her mother-in-law.

There are surely sufficient unconscious feelings of guilt on which to build her fearful, persecutory delusions. It would lead too far to analyze the special symbolic meaning of her hallucinations that somebody enters the house from the basement. It is clear that this can only mean fear of rape. It fits in nicely in the story the patient relates that once a "drunk," armed with a knife, tried to hold her up and that she fought and threatened him away.

It also becomes clear that her repeated assurances of love for her husband mean only hate. This man again makes her play the masculine, caring, active role—and she wants so much to be feminine, soft, charming. She cares now about not having her nail file, her nice clothes, her makeup! (It is easy to conceive that this personality could have developed into an overt homosexual. The homosexuality present is led in heterosexual channels, but unconsciously it has done its work all the same.)

In summary, this well-educated, 34-year-old woman, an only child, with no history of mental disturbances in the family, shows a pre-psychotic personality of the active, superior type. Her phy-

sical typology shows definite leptosomic features (weight, height, shape of face and head). This good mixer and active worker, with extrovert character traits, has chosen a psychosis with both manic and delusional features. Important in respect to the analytical angle is the information from the patient's local physician, that the husband had a hallucinatory psychotic condition and that after her homecoming the patient, without delay, took his hallucinations over and reacted to them. The husband thereupon had a remission. The third purpose of the patient's psychosis had been reached! Now *she* was the weak, feminine, sick person in need of care and help!

This patient imitated, in every respect, the psychotic behavior of her husband: He heard voices and people in the basement; she heard them too. He was certain that a tunnel had been built from a sewer drainage to his basement; she was sure of it too and proceeded to search carefully the garage and vicinity as she described in an elaborate letter to the police. She embellished this letter with "code numbers" on every page and had worked out herself, apparently entirely, an imaginary plot connected with a police search for drug addicts, marahuana, etc., etc. Her husband was shooting in the house; she also took a gun and fired in the room. She showed some originality, however, in inventing the possibility of carbon monoxide poisoning of all of them to relieve them from "insanity." The patient's general history and the introvert, shy period of life in her 'teens offers itself as an enforcing factor to make her diagnosis the same as that of her husband later: paranoid schizophrenia.

A few times, during a period of 12 days, her husband came to see her, and although he seemed apprehensive and tense, no definite symptoms or signs of psychosis could be elicited. On December 9, however, he visited the hospital again and a note in the patient's history elucidates what happened:

"Mr. X, husband of Mrs. X, called at the hospital today and demanded that his wife be released to return home. Knowing the condition of both the husband and wife in this particular case, Mr. X was called to the Superintendent's office and his wife's case thoroughly gone into. It was pointed out that since she blames her entire trouble on her husband's mother, this paranoid delusion might precipitate a tragedy in which the patient's mother-in-law would be murdered. It was further pointed out that other

people's safety and possibly their lives might also be jeopardized through these delusions and mistaken identity.

"After all the sordid possibilities had been discussed the husband insisted on taking his wife home. Since Mrs. X is a Voluntary admission and, according to law, must be released on demand at the expiration of a ten days notice, the ten days were waived, and she was allowed to return home.

"In talking with Mr. X and during the few periods of observation of this gentleman, it is evident that he is mentally incapable of being mentally and legally responsible for any individual and should, himself, be admitted to a mental hospital. It is with great reluctance and only because conditions were such as to make it necessary that Mrs. X was allowed to return home from this institution."

Signed: H. H. Brown, M. D.
Superintendent

Three days later, on December 12, the patient's husband, Professor X, was admitted to the hospital, properly committed by the court. He was quiet and co-operative and his case history as taken six days after admission shows the following. His mother was 70; she had had a menopausal psychosis, a reactive depression for eight to 10 months, but had recovered completely. There had been a positive Wassermann years ago; she was treated with arsenic and bismuth and is now negative. The patient knows that three cousins are psychopathic personalities, alcoholics. No details are known.

The patient completed high school and university and received a degree in pharmacy. He was married twice, first at 25, he was divorced at 26; married again at 26 and is still married. This man had Malta fever and tuberculosis of the lungs while in the army. He was said to have used no opiates, codeine, cocaine or barbiturates. He used a benzedrine inhaler for his nose. His history notes that he used to go for walks at night.

Professor X had been active in high school and university entertainment, dramatics, sports, skiing, literature. He was a good mixer, "dated" first at 14, got along well with girls, was "religious within reason" (Congregational church). He was active during his first two years of college, entertained in his home and at card parties, etc. There was never a serious clash with superiors in

the military service. He had a clash later with the chief of his medical school obstetrics department. Recently there was reported too much strain in work and strong emotional strain; he was not eating enough; there was a clash between his wife and mother.

There had been no previous mental disturbances. The man's physical examination was normal, except for the x-ray of his lungs which showed: tuberculous lesion left apex. Neurologically, there were no abnormalities. His blood and spinal fluid were normal.

This patient's conduct in the hospital was quiet and unobtrusive, although not brooding or apprehensive. His adaptation to environment was good. He was busy making, together with other patients and attendants, the Christmas decorations. His manner was friendly and co-operative. His external mood was pensive, but not depressed, his reaction toward the examiner voluble. He was accessible, free and agreeable.

He entered the office with outstretched hand and smiling. He replied to all questions and produced much spontaneous information.

While his wife was away with their baby to visit her parents, he contracted a right-sided pleurisy. He sought help for this in a hospital. After he came home again he experienced, for the first time, verbal hallucinations. Voices told him to do things. They started talking about him in a frightening way like: "This is the best angle to shoot him"; and "there must be a more quiet way to get rid of him." Later on they ordered him to perform "all kinds of actions," some of them just ordinary, everyday things; others of an aggressive type as if he were still in the army at war, throwing a hand grenade in a dugout. This he did. He threw a big stone through one of his windows. He heard voices at night talking as if he heard a telephone voice muffled; sometimes he could not understand what was said; sometimes it was very distinct.

He began to lose his feeling of security and of being sure of himself, and consulted his physician. The latter advised him to try to take no notice of the voices. He succeeded for a short while, and could even bring himself to prepare and give his lectures in pharmacology and toxicology. This placed him under extreme strain. He did not eat during this period and felt weaker every day. He relates that he even discussed and analyzed for the students his own case as being an intoxication with dilaudid, which

he had taken in the hospital and thereafter to ease symptoms arising from pleurisy.

The voices became so very commanding that he even took his pistol and shot—though without aiming at anybody. In one night he alarmed the police three times, because of the voices and the noises he heard, especially in the basement of the house. One night he went to a hotel and slept there because he could not stand it any longer in his own house.

When his wife came home, found him in a poor physical condition and was told about his experiences, she started exploring and very soon she reappeared in the room "white as a sheet" and stated that she had heard the noises and the voices also. From that very moment, he "snapped out of" his condition and took care of his wife to get her into the hospital.

Once his wife was taken care of, he resumed his hallucinations. Even while he was preparing a suitcase to send to his wife in the institution, the voices did not stop interfering, told him where to look for certain commodities, clothes and toilet articles, and bothered him all the time. He felt as if losing a very solid ground he had always been standing on; his intact, sane mind. Feeling on one hand that everything would become better once his wife would be with him; on the other hand, having noticed the progress his wife apparently had made in the hospital, he urged her to come home.

Once she was home again, everything turned out *not* to be as it had been before. She was tense and apprehensive, strange. He tried to do what was in his power to please her and he described his actions as those of a honeymooner. Nevertheless, things did not run so smoothly as he had hoped and expected they would; and when they had a cup of coffee together in a drugstore, his behavior must have been so strange that his wife ran away and did not return.

It must be added, before following the chronological course of the story, that the night before he had decided that the only thing which would really benefit his wife was a good spanking. This he told her and this he said he did: He spanked her with his bare hand firmly and hard. She did not take it badly, and he thought that it had done her a lot of good.

The period since the drugstore incident was getting hazy in the mind of the patient. He remembered wondering where his wife

had gone. He prepared her coffee for her, but when she failed to return, ran to look for her and when he did not find her, sat down and waited in his car. He stayed there for about three and one-half hours and during this period he had a frightening experience as if he were struck violently on the head. He was in a sort of dream state and voided in his trousers. When, in the end, he was feeling well enough, he went home—only to find the house empty. He was afraid and anxious; he heard the voices and felt utterly unhappy and lonesome. Besides he was weak from exhaustion. He had not eaten much in several days and his pleurisy was still bothering him.

He slept little that night; and next morning everybody was there: his wife, his mother, the doctor, his uncle and the police. They all told him that he had to come to court and that everything was going to be all right. Nobody stopped to tell him what it was all about and he wondered and was puzzled as to what was happening. However, he went to court, behaved quietly during the rest of the day, but in the night became restless again, heard voices, judged that his wife was nervous and tried to "calm her" by showing her a large hunting knife. She was "frightened to death" and took this knife from him. He says that he only held it very loosely, not intending to harm her or to do anything at all with it; that is why she could take it away from him easily. He then was afraid when he saw her running to the exit with the knife that she might fall and hurt herself, so he ran after her to take the knife back. In the meantime, his mother had been warned; and she, in her turn, tried to hold him up and prevent him from reaching his wife. There was a wrestling bout between him and his mother; and in the end he lifted her from the floor and laid her upon the bed.

His wife had reached the door and fell headlong from the staircase to the concrete floor. She broke her arm and had several minor bruises. She succeeded, however in reaching the police; and they came and took the husband to jail. In jail he felt entirely lonesome and forlorn and he experienced his first hallucinations other than acoustic; he did not *see* them, but he *knew* that his ancestors up to the third grade, were there with him and ready to console him and help him. He felt very sorry for himself.

After he came into the hospital, all his hallucinations disappeared at once and he felt much more quiet. He is only worrying

about his wife. He loves his wife above anything in the world, and *he realizes that she has played a too active and masculine part in their marriage,* first financially, later because of his poor condition of physical health. He had been married before, but after less than even a year, he suddenly realized that "this was not the right wife" for him and he divorced her.

He has a very high opinion of his father who died, whereas his mother has always been a strongly domineering personality; and it seems that he feared her more than he loved her. He has several times had severe clashes with her and to relieve his scorn he either slammed the door out of the hinges or broke something at hand. The patient thinks himself to have been more of the introvert than of the extrovert personality.

Additional information by the patient's wife brings out more facts. Although Mrs. X was still in a hypomanic, overtalkative mood, it seems appropriate to take knowledge of the following facts she brings out:

Her husband "acted very strange" after he had taken her out of the hospital. She thoroughly enjoyed the meal in a Chinese restaurant they had together after her discharge. He did not like it and "acted strange." He told her that she was not herself, that she seemed and acted peculiar; he told her to do queer things such as to stand with her face to the mirror; he had ejaculatio præcox in the first sexual act they had during the night after her discharge, but maintained that he had had normal intercourse with her. He continued to hear voices and did not want to sleep in their own house. He "acted extremely strange" in the drugstore where he accused her of having called him a bastard and promised to get even with her, once home. He spanked her, not with his bare hands, but with a hairbrush and, last but not least, threatened her seriously with the hunting knife and told her that he would choke her to unconsciousness.

These facts Mrs. X can prove by the confirmation of an uncle who had been called and stayed with them in their house, as did the patient's mother. This matter has been confirmed by the chief of police.

In addition to this, the wife says the patient spanked and hit her a few more times, the first when he was still in the army base hospital where his actions drew the attention of outsiders. He "ran amok" when he thought his shortcomings as a commanding

officer caused the many thefts from that base. He ran out at night and walked through the hospital. She is convinced that his mental trouble dates back to that period.

The account the patient has given is free, clear and not satisfactory because of hiatuses and because of probable untruthfulness, be it purposeful or not. The patient does not report delusions. In fact he denies having had delusionary ideas at any time. This does not fit with his wife's story. She tells that the patient accused her of not being in the hospital at all; that he said a few spots on her skin* were bug bites she had got in an unclean hotel where she had been with obvious intentions. Furthermore, he accused her of having called him a bastard and said that she acted very strangely. So there have probably been delusions of the persecutory type. Beyond any doubt, the already hostile feelings for his mother which exist in his conscious mind, root much deeper in his unconscious as hate. He idolizes his father, who was "a very fine person" and knew how to cope with the temper and domineering character of his wife. He hates his mother for what she has done to this high-grade man.

Unluckily, this patient had to have the same characteristics in his own wife as in his mother. He divorced his first wife, who was a "nice, lovely, well-bred, educated and well-read daughter of a college professor" and who adored him. He divorced her because of—he can hardly make clear why. He says he realized once he was away from her on a trip that she could not make the wife for him he needed.

He married a woman after this divorce who was an only child, who had a deep unconscious contempt and hate for her own mother and who had in a neurotic way solved her Oedipus attachment by identification with her beloved and highly honored father—who in short, was strongly homosexually inclined. She, therefore, gave him the satisfaction his own incestuous complex wanted: identification with *his* father and ability to punish in his own wife the hated image of his mother. (Knife—phallos-symbol—to attack her!)

We see in a dramatic way in the development of his psychosis the unconscious feelings come to the fore: He tries to attack his wife, to kill her, at the same time having a very real struggle with

*The needlemarks of anesthetic and lumbar puncture.

his mother, herself—and afterward explaining and rationalizing in exactly the opposite way.

Again one sees here symbols coming to the front, "house" standing for "mother." He even admitted, readily, that he identified the house (owned by his mother and for which he pays her rent) with the person of his mother. In the end he could not stand it any longer in that house and fled it. There is much more to elaborate in this field, but it does not seem essential at this time.

Professor X's hallucinations have now disappeared and the patient seems to have gained complete insight as to their character. His mood and nature are not influenced by them now. There are obvious conflict situations in his unconscious which marked the pre-psychotic personality as well as the overt psychosis: ambivalent feelings toward mother and wife.

There is deterioration in judgment. He considered and rationalized his situation, described from a quite different angle than others who were present and took part in the events.

He had been "strange" and "highly strung" years ago. He, himself, admits outbursts of rage whenever his aggression had to be led away from his mother. This pre-psychotic personality was struck with the hardships of army life in an overseas base and with a hard task. He contracted undulant fever, and tuberculosis was detected in a moderately progressed form.

There is a strong trend now on the part of his wife to trace back this whole story of psychotic symptoms to a carbon monoxide intoxication. She has dug into books about toxicology and found points of attack.

She thinks he inhaled carbon monoxide first, then she, after her homecoming. Their baby was having convulsions, and "the cat acted strange." In the hospital, however, where she went with their little boy, doctors did not even look at him, but reassured her *she* says because they knew that she had been a patient in the mental hospital.

The furnace in the cellar of their house was "kind of defective," and she assumes a regular flow of carbon monoxide gases to poison all of them. She also explains her desperate clinging to this solution, because it makes all the difference for the future of all of them. There is, of course, no element of truth in this.

Hallucinations, delusions of the persecutory type (especially jealousy of his wife) but also self-destructive hallucinations, un-

conscious death wishes born from guilt complexes, were the opening phase of the husband's psychosis which the present writer would diagnose as schizophrenia, paranoid type.

Careful inquiry of the local physician and the chief of police, who was handling this case, made it clear that neither of the two patients had told the whole story. It appeared that there had been much more confusion, persecutory delusions, especially on the part of the man, who was certain that people had made a tunnel to enter his house, but also on the part of the wife who had tried to convince the police that her telephone was tapped. There was more aggressive behavior and shooting than could be elicited from their stories. Also the presumption of carbon monoxide poisoning—to enhance which the woman, after her discharge, brought a stack of books on toxicology to the hospital—had to be discarded as a persecutory delusion.

The writer has had and now has the opportunity to observe the wife's conduct and behavior after her hospital discharge, by her frequent visits to her husband and by letters she wrote to him and to the writer. She is still highly hyperactive and certainly has not had the full benefit of indicated treatment.

Summary and Discussion

Here is the strange incident of a conjugal psychosis. The inducer was the husband, who developed in a crucial episode of his life, a frank schizophrenia; but the wife, as soon as she saw the man in this mental condition, jumped headlong herself into it and imitating his hallucinations, passed into a paranoid behavior pattern which appeared to be the same psychosis.

The pre-psychotic personalities of the patients determined the characters of the psychoses they had. Here was an introverted, scientific, brilliant-minded man with blows to his ego—dating from early youth and including illness, dependence in financial matters on his wife, hard and responsible army tasks, possible weakening by the continuous use of drugs (which he denies)—and at last weakening by lack of sleep and food and the toxic working of a new focus of tuberculosis in his right-sided diaphragmatic pleurisy. He entered, with a powerful hallucinatory initiating stage, a schizophrenic psychosis. He obeyed the hallucinatory orders and went even so far as to attack his wife, whom he might have killed with the hunting knife.

Here was also the neurotic woman who was beset with numerous unconscious guilt feelings involving mother-hatred, father-identification, hatred of husband and homosexual drive.

She needed only the suggestive observation of the husband's psychotic symptoms to attract and contract them herself; and she overstepped the borderline of her neurosis into real psychosis with exactly the same hallucinatory symptoms her husband showed.

There are two questions to be considered: Was the wife's psychosis determined by the existence of the man's or would she have become psychotic anyway at some time or another? Is it only the set of signs and symptoms of the woman's psychosis which were determined by the symptoms of the husband's psychosis? Careful reading of the case histories answers both questions. It is obvious that the pre-psychotic personality of the wife made her ready to develop a psychosis at any moment it became impossible for her to face reality. This moment came in the form of a new affliction of her already sickly husband, requiring still more firm and powerful masculine actions on her part. Her feelings of guilt, as described in her case history, made her act in this crucial moment of life as she did; and apparently the outbreak of her real psychosis must be regarded as an escape mechanism which was at that particular instant the only one she could rely upon.

Again she proved that her deepest desire (unconscious) was to be the weak, dependent and cared-for woman, in accepting and taking over without alteration the symptoms of her husband's disease. She also proved that her feminine imagination was able to work out his delusions and hallucinations in a much more creative way than he had been able to do.

The answer to question one should be, therefore, that the wife was predisposed by her pre-psychotic personality to develop a psychotic picture whenever environmental factors made it impossible for her ego to make a proper adjustment. The reasons she assumed the husband's symptoms have been discussed.

ACKNOWLEDGMENT

The author wishes to convey his heartfelt gratitude to Dr. Alexander Gralnick of New York, for his co-operation in letting him have for study the entire current literature on the subject under

discussion. His paper, "Folie à Deux—The Psychosis of Association," in THE PSYCHIATRIC QUARTERLY, 1942, has already been referred to; it gives a complete list of the literature.

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THE PSYCHOSIS OF ASSOCIATION: FOLIE À DEUX

A Case Presentation

BY RALPH ZABARENKO, M. D., AND JAMES A. JOHNSON, M. D.

Introduction

Case presentations and discussions of the psychosis of association still remain relatively few. However, as Gralnick[1, 2] pointed out, this mental disorder may not be so rare as we generally assume. The recognition of the disorder may be of considerable importance in our dealing with the psychotic patient and his family or other associates. Further, the material which this condition offers in the study of interpersonal relationships cannot be ignored.

"Folie à deux" which literally means "psychosis of two" is a term usually attributed to Lasègue and Falret (cited in Gralnick,[1] April 1942), and first used in 1877. Gralnick[1] writes: "*Folie à deux* is a psychiatric entity characterized by the transference of delusional ideas and/or abnormal behavior from one person to one or more others who have been in close association with the primarily affected patient."

Since the details of separate cases vary, it is probably worth while for purposes of classification and further study to use the subtypes which appear in Gralnick's article. These also aid in broadening the concept of what constitutes the psychosis of association. They are as follows:[1] "(A) *Folie imposée* (imposed psychosis) was the type described by Lasègue and Falret in 1877. Although they coined the term which eventually covered all the types, they delineated this particular group only. In imposed psychosis, they said, 'The delusions of a psychotic person were transferred to a mentally sound one, but it was necessary for the persons to be intimately associated and free from counterbalancing forces.' Further, the disease in the second, they held, did not run a typical course, but tended to disappear as soon as the two were separated. They point out that in the second person the delusional trends are not elaborated by the individual himself, but he offers little resistance to their acceptance.

"(B) *Folie simultanée* (simultaneous psychosis) was first described in 1880 by Regis. He said that in this type there simultaneously appeared identical psychoses, characterized by depres-

sion and persecutory ideas in two morbidly predisposed persons. He pointed out further that those involved should have an intimate and long association, and that the psychoses appeared directly after accidental causes, usually of a depressive nature.

"(C) *Folie communiquèe* (communicated psychosis) was first described in 1881 by Marandon de Montyel who said that in this type there was a contagion of ideas, but only after the second person had resisted them for a long time. After finally adopting the delusions, the involved person maintained them, even after separation from the first. As Carrier puts it, the second one erects a system, in which certain delusions are communicated by the active subject and others are peculiar to himself, depending upon his previous personality and previous disposition.

"(D) *Folie induite* (induced psychosis) was first described in 1885 by Lehmann. He said it was a type in which new delusions were added to those of a patient under the influence of another patient."

Case Report

This case is presented as an instance of the psychosis of association occurring in husband and wife. The term "primary agent" will be used for the first person to become delusional, and "recipient" for the second. The wife, W. B., was an in-patient at the Western State Psychiatric Institute and Clinic, Pittsburgh, Pa.; the husband, H. B., was not hospitalized. However, he was interviewed by the writers on several occasions. Information was also obtained from the wife's relatives as well as from husband and wife.

W. B. was an attractive 34-year-old woman who was the fourth of five siblings. The youngest sibling had died at the age of three and one-half years of influenza; the others are alive and in good health. Her father was a highly-respected police officer who was shot and killed in a vice raid when the patient was 12 years old. W. B.'s mother was very dependent upon her husband and, following his death, became fearful, "nervous," and very possessive of all her children. The mother warned the children that their lives were probably in danger; she went about the house, drawing the shades to prevent any attack from gangsters upon the family. Other than the "nervousness" of W. B.'s mother, there was no history of nervous or mental disorders in the family. The family was of average economic and social standing in the community.

There was nothing unusual about the birth and early development of W. B. There was a history of rheumatic fever at the age of six with no residual damage. The girl was an average student, was graduated from high school and took a short course in business administration. After finishing this course, she obtained a good job as a secretary and continued to live with her mother. At this time the other siblings had left home and had married. The mother continued to be very domineering and possessive of W. B. In spite of this, the patient led a fairly active social life although she was not permitted to bring friends to the house. At this time W. B. dramatized herself a great deal, dressed in the latest style, and spoke much of wanting to be an actress or a ballet dancer. She had several love affairs, but her mother discouraged them and continued to emphasize that she must get a man of high financial standing. After a courtship of a few months, however, the girl married H. B. in 1942. About two months after the marriage, the husband entered the armed forces and served nine months in the army. When he returned to his wife she was greatly surprised to discover that he was unable to support her and that it was necessary for her family to lend them money "to get them started." H. B. seemed to have difficulty getting, and keeping, a job from that time on.

The husband was 40 years old and had a general appearance of distinction. In spite of the fact that he was heavily in debt, he was extremely well dressed. He was the youngest of three children, there being two older sisters. H. B.'s father had died when he was a young boy. H. B. was graduated from high school and then attended seven months of night college. Since childhood he had always said that he wanted a white collar job and that "just anything" would not be good enough for him. He lived with his mother in her apartment until 1934. Much of this time he was completely supported by his mother who gave him whatever he wanted. He went from job to job and was not satisfied until he became a civilian inspector for the navy, which was his occupation at the time he met and married W. B.

In July of 1944 W. B. gave birth to their only child, a son. Following this delivery, she developed what was diagnosed as a postpartum psychosis and was hospitalized for about five weeks in a psychiatric hospital. Following this illness, the couple had considerable financial difficulties because H. B. could not find and hold

a job; he also began to drink rather heavily. In September of 1945, they moved to Arizona. Since the man could not find work, W. B. began to work as a bank clerk and placed her child in a foster home. In about nine months the husband wanted to move to California. As soon as they arrived in California, W. B. began to feel nauseated, "as if I had been poisoned. I said to myself I've eaten something."

Again the husband could not find satisfactory employment so his wife began to work as a secretary in a medical clinic. She then began to tell her husband of her sensations of fatigue and of her feeling that she was being drugged. The man threatened separation if she did not stop talking about being drugged. W. B. began to smoke, which was unusual, began to talk to strangers, and to feel weak in the knees. Finally she went to the medical clinic where she worked and openly accused one of the doctors of being a Nazi and of sterilizing women. She also went to a juvenile court and began "pushing the policeman around" for no apparent reason. Because of this behavior, she was committed to a state hospital in August 1947; she was discharged in September 1947, at which time she and her husband returned to Pittsburgh. On their return, both of them went to the federal narcotic bureau to report that they had been poisoned in California and declare that something should be done about it.

Following a therapeutic abortion and sterilization in January of 1948, W. B. began talking about being poisoned in Pittsburgh by Communists. Because her husband was still unable to support his family the wife sought aid from Family Service. It was recognized by this organization that she needed psychiatric help and she was then referred to the Western State Psychiatric Institute.

W. B.'s physical examination, laboratory tests, and x-ray studies were essentially negative. She told the story of being poisoned in California and, for that reason, being placed in a psychiatric hospital because of her peculiar behavior, which she attributed to the drugging. She asserted that she and her husband had both been drugged by a woman neighbor in California. W. B. also said that she was being given drugs by various methods in Pittsburgh, probably by Communists and other enemies of the United States. The patient was quite hostile when she said that her husband did not accept her theories of the poisoning in Pittsburgh. W. B. was

tense, suspicious and somewhat hostile. She was circumstantial, but her affect was inappropriate to the mental content. She was well oriented, of average intelligence, and her memory was good.

At the time of W. B.'s admission to the hospital, she and her husband had been separated for about a month. When H. B. was interviewed for the first time, he said he felt that his wife's difficulties were caused by the drugs which had been given to both of them in California. He then went on to tell how "weak and strange" he felt when he had been given a highball by the woman neighbor whom they accused of this drugging. He was rather vague and circumstantial when questioned about the possibility of his wife's being poisoned here in this city; however, he did state that such things as "cold warfare do occur." H. B. constantly asked for reassurance that he was not to blame for his wife's "nervous upset." At other times he would openly blame the weird happenings in California for his wife's unhappiness and "nervousness." The husband said that their financial situation had been very poor in California; however, he said that he was about to get a very good job in California when this unfortunate situation developed. In several interviews, H. B. continued to attribute the entire situation to the drugging in California.

W. B. became more and more excited and hostile during her stay in the hospital. She began to accuse the hospital personnel of poisoning her and of being enemy spies. She became greatly upset after her husband visited her and sometimes would cry, saying "Even he doesn't believe me." She refused any type of therapy and finally, on her own demand, was released from the hospital.

Discussion

This is a case in which the wife, W. B., is suffering from schizophrenia, paranoid type, and is the primary agent in the psychosis of association. The husband, H. B., is the recipient. From the beginning of this pair's association in marriage, the woman took the more dominant role in the relationship; she even took over the usual masculine role of supporting the family. The man presents a life-long picture of the immature dependent, passive and insecure type of personality.

After moving to a new locality and environment, which they both felt held greater possibilities for their life together, the stresses

and disappointment seemed great enough to precipitate a psychotic episode in the wife. She was again impressed with the inadequacy of her husband and was forced to neglect the care of her child to earn the money which H. B. did not provide. As is so often found in the psychosis of association, the fertile ground of threatening poverty was present. In addition to these same stresses, H. B. was now faced with a psychotic wife and an awareness of his own inadequacy. He reacted by adopting his wife's delusion that she had been poisoned and that this was the cause of her unusual behavior (psychosis).

The adoption of his wife's delusion presented H. B. with an easy, though pathologic, mode of adjusting in this association. To accept the delusion was one more way for him to gain and to hold the much-needed support from his wife; the fulfillment of his needs for dependence would certainly have been lost had he rejected the delusion. This delusion made it easier for H. B. to accept his wife's illness and his own economic failure. He did not fully accept his wife's more recent delusions, however; the pair were separated much of the time after their return to the Pittsburgh area, and their association was not so intimate. It is interesting to note that W. B. became more hostile and excited when her husband failed to accept these more recent delusions. She said, "Even he doesn't believe me." Thus, the adoption of the delusions by the recipient seems to gratify certain needs of the primary agent.

This case of psychosis of association is best classified as the imposed type (imposed psychosis).

The wife's paranoid delusion was adopted by her mentally sound husband after the two had been intimately associated. The delusions were not elaborated by the recipient and tended to disappear when he was separated from the primary agent, his wife.

Summary and Conclusions

A case of psychosis of association, imposed type, is presented. The following principle features were present:

1. The primary agent (wife) was a paranoid schizophrenic; and the recipient (husband) had been a non-psychotic but very dependent personality, before the onset of the imposed psychosis.

2. The recipient adopted, but did not elaborate, the delusional system of the primary agent.

3. The recipient's symptoms tended toward remission during a period of separation from the primary agent.

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THE USE OF INTRAVENOUS SODIUM AMYTAL IN PSYCHIATRIC FEEDING PROBLEMS

BY PHILIP P. STECKLER, M. D., AND LEBERT HARRIS, M. D.

Although the literature on the use of intravenous sodium amytal in psychiatric problems has been extensive, its specific application in feeding problems has received little attention. In mental hospitals, the usual method of handling feeding problems is by the utilization of gavage, forced feedings or intravenous fluids. It is the purpose of this paper to bring to the attention of interested physicians another method of feeding psychotic patients, which, in the hands of the authors, has been found to be simple and efficacious.

The pharmacological properties of iso-amyl ethyl barbituric acid (amytal) have been discussed at length. (Burnett, Waldo Emerson.[1]) A brief summary of the main effects is as follows: Changes in the peripheral circulation have been noted, respiration becomes shallower, and intestinal tone is diminished. Slurring of speech, vertigo and diplopia may occur. Masserman's studies show that the barbiturates act on the diencephalon. Electro-encephalographic changes have also been noted. It has been the writers' experience, with that of other authors, that intravenous barbiturates cause a release of affect.

Method

Depending on whether the patient is actively or passively negativistic, one of the two following methods may be used. The passive patient is seated on an ordinary chair with a towel draped around him. An attendant stands behind him to keep the patient's head erect. Another attendant assists the physician in the administration of the medication; sodium amytal, 7½ gr., dissolved in 10 cc. of sterile, distilled water, is injected slowly into one of the accessible veins of the antecubital fossa. When at least half of the solution has been given and the patient shows a reaction, either by increased psychomotor activity or somnolence, an attempt is made to have him drink milk or eggnog from a cup. Usually the patient will show some mild resistance, but is easily encouraged by forceful direction and suggestion on the part of the physician. In the experience of the authors, once the initial re-

sistance to the ingestion of food is overcome, the ordinary diet can be fed to the patient with relative ease and in large amounts. The patient then becomes increasingly somnolent and will sleep for a variable time. In the case of the actively negativistic patient, at least three, and preferably four attendants should be present in the initial stages of the feeding procedure. The patient is restrained manually in bed; and the medication is given as described. The patient is then propped up in bed with several pillows, and a towel is draped around him. The procedure from then on is as just described.

Results

Sixty-four patients at Syracuse Psychopathic Hospital, during a period of two years, have been fed by this method. Although five patients could not be fed on the first attempts, these same patients were fed successfully, following correction of the technique used.

Illustrative Cases

Case 1. This is a 40-year-old woman with a history of active tuberculosis for which she had been hospitalized for the past year. For the past six months, the patient had withdrawn from her surroundings and, immediately prior to admission to the hospital had attempted suicide by cutting her wrists and throat. On admission to this hospital, the patient was resistant and actively negativistic. She refused all food, and it was decided to feed her by means of sodium amytal. On the second day in the hospital, sodium amytal, 6½ gr. was given intravenously and the patient was fed 1,000 cc. of eggnog, 200 cc. of water and a large bowl of rice pudding. At the next meal, the patient refused to eat. However, at the following scheduled meal, the patient ate the regular diet by herself—served to her on a tray. From that point on, until her discharge, she continued to eat at the appointed times. She was discharged from Syracuse Psychopathic Hospital to a larger state hospital for prolonged care, because her psychosis was persistent although active negativism in regard to food was no longer a problem.

Case 2. This case is that of a 23-year-old single veteran. He was admitted to the hospital because he had "lost his appetite" for about a month and had lost 39 pounds in that period. Imme-

diately on admission, the patient showed evidence of passive negativism and at first it was decided to force-feed him by means of gavage. After two tube-feedings, the patient acquired the knack of passing the tube himself and would not permit it to be passed by any of the physicians. It became apparent that this was serving his masochistic purposes. On the fourth hospital day, he was given sodium amytal, 5 gr., intravenously. The patient then took 2,000 cc. of eggnog. Following this feeding, he stated, "As long as you are forcing me to eat, you should please give me your regular diet and include ice cream and chocolate cake." Accordingly on the next day, the patient received sodium amytal, 7½ gr., in the usual manner. The tray was placed before him and a spoon put in his hand, and he was instructed and encouraged to eat the contents of the tray. Following that, he drank 200 cc. of eggnog and ate two dishes of ice cream. He continued to refuse food and for the next 10 days was fed with the aid of sodium amytal. At the end of that period, the patient began eating without the use of barbiturates and continued to eat large portions from that time until his discharge. On admission, the patient's weight was 114 pounds, 10 days later, 119 pounds, 14 days after that it was 130, and three weeks later, on discharge, 151. This patient was also transferred for prolonged hospital care because of his psychosis.

Case 3. This patient is a 22-year-old married man. On admission to the hospital, he was violent, excited and disturbed, and resisted feeding. When food was placed in his mouth, he would spit it out. He remained acutely disturbed for about two weeks. During this period, he refused to eat at all times and was hydrated by means of intravenous solutions while under heavy sedation. On this regimen, the patient began to lose weight, and it was decided to attempt to feed him by means of sodium amytal. It was found that, with the administration of this barbiturate, the patient would not refuse regular diet trays.

Contraindications

Except for stuporous cases of undetermined etiology in which organic factors seem to predominate, the writers have found no contraindications for the use of this method. Lundy and his coworkers[2] state that the site of destruction of pentothal is not definitely known. It, therefore, appears that there is no reason to

withhold this procedure from patients with hepatic or renal disease.

Discussion

Usual methods of feeding patients refusing food, that is, intubation, intravenous fluids and forced feeding all have their disadvantages. Intubation has many dangers and is not an entirely physiological procedure. The salivary digestive enzymes are bypassed and the starches are not properly utilized. Often the efforts of the therapist are negated by the patient's rejection of a greater or a lesser amount of food so ingested. Attendant dangers of asphyxia and of trauma to the posterior pharynx are great, especially when intubation is in inexperienced hands. Aspiration pneumonia and sudden death are occasionally encountered. The masochistic demands of many depressed patients are gratified by intubation, thus tending to perpetuate its use.

Intravenous feedings present the problem of insufficient caloric intake and excessive cost. There is also the mechanical problem of maintaining the intravenous flow in a disturbed patient.

Forced feeding usually precludes sufficient caloric intake, as more food is usually wasted than ingested, despite the best efforts of attendants.

The advantages of "amytal feeding" are its ease of application, adequate caloric intake, and lack of regurgitation. The digestive process is entirely physiological. No special foods are necessary and the patient can be fed whatever is available. Although amytal feeding may be used over prolonged periods without toxic effects, it has been the writers' experience that, following the first few feedings, the patient will usually eat spontaneously. From the psychological viewpoint, there are also many advantages. One readily notices a temporary regression under amytal to an infantile level of existence; and this may be used to advantage because the patient will respond to the same type of suggestions and direction accorded a recalcitrant child. There is no tendency to perpetuation of the procedure in masochistic individuals, as they do not have to be forced and usually feed themselves. Under the influence of this drug, contact with inaccessible patients can often be established and their reasons for refusal of food may be revealed. They are receptive to suggestions that they are hungry and that they are able to eat, and these suggestions are usually acted on by the pa-

tient after the effects of the drug have worn off. Some difficulties have been encountered because of the rapid onset of narcosis, but the experienced therapist soon is able to judge the effective dose.

SUMMARY

A method for feeding negativistic patients in institutions, which has been found to be superior, in many respects, to the customary methods, is presented here. This method was used in 64 cases with success in all instances.

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PSYCHODYNAMIC MODIFICATION OF ELECTRIC SHOCK TREATMENT

BY J. ROBERT JACOBSON, M. D.

The advent of the somatic approaches in the treatment of mental illness has brought about revolutionary changes in empirical therapy. Shock treatment has placed in the hands of the psychiatrist a sharp instrument, as sharp as the knife of surgery, and the possession of such an instrument brings with it new responsibilities. The indiscriminate administration of the physical treatment, without the development of an adequate medical psychology in harmony with it, is certain to bring into disrepute the relatively severe forms of psychiatric therapy.

The effective employment of the shock therapies carries with it implications for our psychiatric orientation. The use of electric shock treatment as a specific in the affective disturbances brings to the psychiatrist a tool similar to that employed by the medical man when he uses quinine in malaria, penicillin in the appropriate bacterial diseases, or digitalis in heart disease. It is quite true that we do not have a knowledge of the etiology of the affective disturbances comparable to our knowledge of the malarial parasite or of the staphylococcic and streptococcal infections. From an empirical standpoint, this does not matter.

The effective use of a physical modality to change mental disease emphasizes that a malfunctioning personality can be directly influenced by a physical process so as to bring about personality equilibrium. An explosion of cerebral energy brings about a restoration of mental health. Infantile conditioning, complexes, and malfunctioning which are presumed to underlie mental illness have not been explored. Buried dynamic material has not been brought to consciousness. No "depth psychology" is involved.

There is a need in psychiatry for the formulation of a psychobiological orientation to the use of the shock therapies which will dignify that use, and around which clinical experience can be organized so that further refinements in specialized therapy can be developed. The triad of ego, super-ego and id provides an inadequate clinical orientation for the application of the somatic procedures. This triad is associated with the concept that basic psychopathology centers around distortions of personality arising from dynamic patterns laid down by the influence of the super-ego and id in infancy and early childhood.

The use of a *present* treatment modality requires a different orientation. Instead of the "ego" one deals with the *person*, the *whole man* of Hughlings Jackson. This *whole man* is the most important expression of brain function. The person, the whole man, is the mental counterpart to the whole body. *He* represents the associative activity of the whole brain acting as a unit. *He* sees, *he* speaks, *he* hears, *he* smells, *he* moves his right arm, *he* sits, stands, moves the whole body. *It is this whole person whom we are directly influencing when we bring about cerebral physiological changes. The whole person changes as a result of a direct environmental stimulation. The triad of person, affect, and present environmental contact can be associated with the concept that the basic psychopathology underlying mental illness is a distortion of the relationship between person, affect, and environmental stimulation.* This triad gives psychiatry a psychobiological background for the functioning of personality and places it on a sounder medical footing.

The person (the whole man) is constantly under the influence of affective dynamic forces. He is depressed, anxious, guilt-stricken, irritable, panicky, resentful, enraged, antagonistic. While he is under the influence of these affective forces, he is relatively more withdrawn and less aware of the environment. When he is functioning at the peak of his efficiency, he is in maximal contact with the outer world and exercises maximal interest, attention, and concentration upon the tasks he is performing. His maximal energy is employed in his present job. Brain function revolves about the fluctuations between full interest, attention and concentration in some present task, and reduced levels of brain function when the person becomes fatigued, loses interest, and becomes involved in affective cycles of depression, anxiety, guilt, worry, fear, perplexity, irritability, and hostility.

Electric shock treatment is especially effective in the affective psychoses. An electrically-induced epileptiform discharge brings about clinically a state of coma. The depressed individual awakens from his postconvulsive coma with a profound change in his affect and a returned flow of energy toward his environment. The essential features of the mental illness were the quantity and fixation of the affect; the reduction of the person to a state of helplessness to modify that affect; and the loss of availability to the person of the energy bound up in the depressive train of ideas. In the schizo-

phrenic who is rigid, withdrawn, and unresponsive, the brain energy available for adaptive response to the environment is reduced. The rigidity of the person is a distortion of the organization of the person. This distortion is the essential illness. The *person* is the means of contact with the environment on the one hand and with the affective sympathetic nervous system responses on the other. *The basic psychopathology is the distortion of personal orientation to the environment.*

Although consciousness is immediately lost in ordinary electric shock treatment and the initial panic reaction preceding the convulsive discharge that was present in metrazol therapy does not exist, the patient does experience very disagreeable subjective reactions. He repeatedly verbalizes his fear that he is to die, and he may accept death with resignation or violently resist the death threat. Though electric shock treatment is a physiological agent which alters brain function, as evidenced in personality changes, it also introduces into psychiatric practice a tremendous pressure variant in the patient's environment.

The present writer developed a technique whose purpose was the organization of the psycho-physiological aspects of electric shock treatment. In the presence of the nurse and the attendant, each patient was interviewed before the treatment, and questioned about his progress, his past experiences, and his future plans. The degree of his insight into the nature of his illness was explored. The nurse and the attendant reported on improvement or lack of improvement in his behavior since the last treatment. It was carefully explained to the patient that the treatment was designed to change the way his brain functioned, so as to make possible an improved adjustment on his part sufficient to enable him to return to his family. Correction of some specific feature in his illness, of some difficulty in adjustment, was described to him as the goal toward which this treatment was being directed. The patient was told that to the extent to which he was able by his own efforts to reach that goal, shock treatment would become unnecessary. The patient was strongly motivated to avoid further treatment. The doctor constantly emphasized that he too wished to eliminate the necessity for further treatment, by developing within the patient a stabilizing factor that had been lost. Affects of depression were emphasized to the depressive patient; euphoria and loss of restraint to the manic patient; the loss of control over anger, re-

sentment, and paranoid projection mechanisms to the paranoid patient. This technique was based on a recognition that the shock treatment situation included a pressure situation which strongly motivated the patient along any lines of thinking and behavior which would eliminate the need for further treatment. Electric shock treatment was thus utilized as part of strong group pressure to bring about a return to normal social motivation and effort.

Over a period of some time, it became evident that the skillful, organized use of the psycho-physiological aspects of electric shock treatment brought about appreciable results. It introduced into ordinary electric shock treatment a rationale that dignified its use. It was apparent, however, that the psycho-physiological aspects of orthodox electric shock therapy were the by-products of the treatment procedures, and that their control was cumbersome and inadequate.

The writer found that the Liberson brief-stimulus machine was much better adapted to the control, modification, and intensification of the psycho-physiological aspects. With this machine, one can administer a minimal current which produces a disagreeable subjective effect without any significant alteration of consciousness. The systematized use of this form of treatment presents problems of adjustment for both patient and therapist. Although there are physiological effects, this treatment is primarily psychological. The patient is faced with the necessity of adjusting to a difficult therapeutic situation. The relationship of patient to doctor is greatly intensified. The use by the therapist of a modality which profoundly arouses the patient brings about a dynamic relationship between patient and doctor. For these reasons, the writer selected the term "psychodynamic electrotherapy" as an appropriate designation of this form of treatment. Throughout the hospital with which the writer was associated (the Territorial Hospital, Kaneohe, T. H.), this modification of electric shock treatment soon became known under the initials PET!

When the Liberson apparatus is employed subconvulsively, the treatment duration is placed at the continuous mark, the pulse duration at .3. The milliamperage is controlled as one presses the treatment button. It is best to give an initial milliamperage up to 100 or 150. At this level, the musculature of the face is so contracted that speech is impossible. The treatment button is pressed for 3 to 5 seconds. Then, during an interval of 30 seconds to one

minute, one talks to the patient and aims at some therapeutic objective. The patient may be stimulated a variable number of times, depending upon the success in achieving one's objective for a particular therapeutic session. There may be relatively few active treatments in one session, or there may be as many as 10 or 12.

The technique advocated by Liberson places the indifferent electrode over the vertex and the active electrode in the left frontal region. The writer modified this technique and placed the electrodes over the right and left frontal regions. This somewhat increases the disagreeable central effect; and, if a grand mal seizure is desired, it can be more readily induced. If the leads are placed over the parietal region the disagreeable central effect is noticeably increased, and a grand mal seizure can be induced with much less current.

It has been the author's experience that PET alone does not replace electric shock and deep insulin therapy. Sufficient control studies, to determine to what extent a good quality of improvement or remission may be secured by subconvulsive therapy alone, have not been made. The writer has, however, treated enough patients with this modality to indicate that PET alone as the initial approach in the treatment of acute schizophrenia is relatively ineffective. There should be a preliminary course of 10 to 12 electric shock treatments, followed by six to 10 psychodynamic electric therapy sessions. A number of patients received such courses of treatment, and then had deep insulin therapy. Maximum clinical improvement was obtained in a number of cases only after deep insulin therapy followed by PET. In those paranoid conditions where deep insulin therapy was not given, a course of electric shock treatment was followed by psychodynamic electric therapy. The purely somatic procedures facilitated the effectiveness of the response to PET. In the involutional psychoses, a course of 10 to 12 electric shock treatments followed by six to eight PET sessions, represented a course of treatment. In a number of cases in which the initial response to one such course was ineffective, repeated courses were occasionally effective. In some very resistant cases, PET was employed over a long period as an aid to individual psychotherapy, group psychotherapy, and occupational therapy.

The important feature in administering psychodynamic electric therapy is the setting of a goal. One first aims at a personal con-

tact with the patient, and asks him about his past experiences, his immediate family, his occupation, his illness. One does not aim at any profound discussion, but primarily at obtaining a personal relationship between doctor and patient. One points out to the patient the analogy between the painfulness of the present treatment situation and the unpleasant affective disturbances he has experienced in his life situation. A parallel is drawn between the painfulness of anxiety and depression and the painfulness of the electrical stimulation. One aims at the development by the patient of a more stoical attitude toward the immediate disagreeable stimulation. One acts upon the assumption that the essential feature of the illness was an absence of a quality of stoicism in the life situation. The acting-out of this quality under the conditions of therapy serves as a starting point for a similar stoical attitude in the life situation.

The indifferent patient is given the goal of becoming more energetic and working harder. Rigid, withdrawn, unresponsive patients are given the goal of becoming more friendly and responsive. The hostile patient is influenced to become more friendly and cooperative. Patients with a tendency to emotional oscillations are given goals of stabilization. Patients who show a tendency toward panic reactions are influenced to develop more courage.

The introduction to the treatment is given as follows: "This treatment is going to be somewhat disagreeable. I do not want to hurt you more than I have to. I cannot give this treatment unless you co-operate. I am sure you want to get well, to leave the hospital and go home. I will make every effort to reduce your discomfort to the minimum. You must endure the discomfort to the best of your ability." A relationship is established between doctor and patient in which they have a common goal of reducing the patient's discomfort and increasing his control.

Patients describe their reactions to the treatment itself in various terms. Some of them say, "It is hot . . . very hot." Others speak of pain. The writer, together with a group of normals, personally experienced the treatment. He would describe one effect as that of myriad pinpoint, prickly sensations over the entire scalp. The disagreeable central effect was that of a severe vibratory sensation which gave him a feeling of helplessness and extreme discomfort.

Some patients developed marked emotional reactions, commonly depression, and cried bitterly. In some cases, very violent emotional reactions were developed and the patients went back in their emotional life and gave productions which reminded one of some of the results of sodium amytal or sodium pentothal administration. For example, one patient cried bitterly and said, "Oh, I know I've been a bad girl . . . but don't beat me again! I've been beaten enough in my life. My father used to beat me with a whip because I was a bad girl." She was obviously thrown back in time to early childhood experiences which she was abreacting. Euphoric responses sometimes occurred, and the patients became rather pleasant, elated, friendly, and garrulous. One patient showed no evidence of discomfort, but said, "It doesn't hurt. It feels good. I like it." One may speculate that this patient was masochistic, so that for her the administration of a painful stimulus resulted in pleasure.

A very violent, hysterical, delirioid type of response took place in some patients under minimal milliamperage so that it was apparent that this was primarily an emotional reaction to the setting and not a response to excessive pain. Some of these patients showed the same reactions in later sessions when no current was administered, again showing their fragile personality make-ups. There was a mechanism of panic-stricken flight in which the individual threshed about, the eyes rolled wildly, and no significant, relevant responses to the environment could be obtained. In such cases, placebo administrations of no current were instituted until the patient became more stabilized in the treatment setting.

A table showing the number of patients of different types given psychodynamic electric therapy in the course of one year, from the time the writer instituted this modification of electric shock treatment until he left the Territorial Hospital, is given here. The statistical evaluation of this form of treatment does not constitute the best measure. There may be relapses and some of the levels of stabilization may be questioned. This same problem has been frequently emphasized in the statistical evaluation of the shock therapies. But, although one may question the percentages, no one questions the clinical value of shock treatment. Similarly, one may question the percentages shown in the statistical evaluation of the psychodynamic modality. The significant thing is not the figures, but the fact that the psychodynamic modality was effective

RESULTS OF PSYCHODYNAMIC ELECTRIC THERAPY IN 310 CASES OF MENTAL ILLNESS

Type	Total number	Improvement None	Slight	Moderate	Marked	No. discharged
Acute schizophrenics: residual personality defects	59		6	5	48	44
Chronic schizophrenics	163	35	8	80	40	42
Paranoid conditions and involutional paranoid disorders	32		4	4	24	22
Senile paranoid psychoses	1				1	1
Acute manic states	15		1	1	13	13
Chronic manic states	2				2	1
Psychopathic personalities	24		1	1	22	22
Behavior disorders, mental defectives	3				3	3
Behavior disorders, epileptics	4	1			3	1
Psychoneurotics	7		1	1	5	6
Totals	310	36	21	92	161	155

in cases in which there was no other effective therapeutic approach. It succeeded where other modalities failed. Without it, we would have been helpless to influence the course of the illness.

RESIDUAL PERSONALITY DEFECTS IN ACUTE SCHIZOPHRENICS

Patients who had been ill less than two years were included in the acute schizophrenic group.

Number treated	59
Marked improvement	48
Moderate improvement	5
Slight improvement	6
Discharged	44

We are all familiar with the acute schizophrenic who has had electric shock and deep insulin therapy but who shows residual personality defects. The patient who remains somewhat rigid, withdrawn, and relatively unresponsive, loosens up under psychodynamic electric therapy; becomes more friendly and responsive; and shows a better quality of spontaneity and energy in working. A typical illustration is a patient who continued to be defensive, rigid, and withdrawn after extensive electric shock treatment and a complete course of deep insulin therapy. Further courses of electric shock treatment brought about some improvement in her immediate adjustment, but no rapport or discussion of her personal problems was possible. Under PET, she showed intense af-

fect and talked about her personal problems and her difficulties with her family. The catharsis and abreaction of affect was much more intense than that usually obtained under amytal or pentothal. After her defensive schizophrenic façade was penetrated, she developed marked friendliness to the doctor and talked about her constructive plans to improve her immediate behavior and attitude so as to make possible her release from the hospital. Her level of adjustment steadily improved. She worked well, was pleasant and co-operative, adjusted well at home on week-end visits, and eventually went home in a fairly good state of remission. Her convalescence was materially accelerated and her stay at the hospital shortened, through the use of psychodynamic electric therapy.

Another type of residual defect is that in which the patient lacks energy and remains apathetic and emotionally flattened. The psychodynamic modality is effective with these patients. They brace up, become more energetic, are more alert, and the emotional tone is decidedly improved. It is quite a common thing for such patients to say that they think more clearly and that they feel stronger and more active. One does gain the impression that the physiological effects play a role in the personality improvement. An illustration is a young man of 18 who had extensive electric shock and a full course of deep insulin therapy. He continued to be markedly flattened and indifferent and did no work. The usual procedures of psychotherapy and occupational therapy were relatively ineffective. His response to PET was striking. He quickly became noticeably more alert, brisk, and energetic. He worked reasonably well and in a relatively short time reached a level which made it possible for him to leave the hospital. He continued to adjust at home on a fairly good social level.

Still another type of residual defect is that in which the patient is rigid, with an emotional tone of resentment and a varying degree of expression of active hostility. Psychodynamic electric therapy is peculiarly effective in dealing with hostility reactions. One directly confronts the patient with the fact of his "bad" attitude toward those about him and one continues to treat him until one is convinced that his attitude has changed, at least momentarily. One then aims at the patient's acceptance of his responsibility for controlling his hostility and becoming more friendly with those about him. One of the most striking effects of this therapy

was the change in such patients from a sullen, hostile, antagonistic attitude to an attitude of friendliness and co-operativeness. They developed a genuine attachment to doctor, nurses, and attendants.

Other cases of acute schizophrenia who fail to respond to electric shock and deep insulin therapy, do not fall into the patterns just described. For example, a 30-year-old married woman who became ill shortly before her admission to the hospital, continued to hallucinate actively after extensive electric shock and deep insulin therapy. She showed malignant regressive features which changed what had appeared to be a catatonic picture into one of hebephrenia with considerable dilapidation of thinking. She responded irrelevantly, incoherently, or not at all. Her first response to psychodynamic electric therapy was one of fear of the treatment. The panic into which she was precipitated under this stimulation was regarded as a healthy return of an appropriate emotional response to environmental forces. In terms of her fear, contact was re-established. The doctor expressed sympathy for the patient and pointed out to her that her panic and her running away from her personal problems was the chief reason for her difficulties. In her distress, she turned to the doctor for help and guidance and in the course of subsequent treatment sessions increasingly looked to him for authoritative support. He became the symbol of her return to contact with the hospital personnel and her daily institutional routine. The bizarre hebephrenic symptoms disappeared. She socialized on a progressively higher level and was in a good state of remission when she was paroled.

Another example of an acute schizophrenic who failed to show any improvement following electric shock and deep insulin therapy is an 18-year-old girl who had had a long history of traumatic sex experiences with her step-father. In her acute illness she actively hallucinated. She responded to voices which constantly repeated the details of her sex experiences and induced depressive affects, marked guilt reactions, seclusiveness, withdrawal, and antagonism. Under psychodynamic stimulation she became friendly, looked eagerly to the doctor for help, expressed hope for the future, and verbalized her ability to diminish her response to the voices. She progressively improved and was in a good state of remission when she left the hospital.

Chronic Schizophrenics

There is a vast difference in chronic schizophrenics. When psychodynamic electric therapy was first given to chronic schizophrenics, the more favorable types were selected and they showed a relatively good response. When the older, more deteriorated cases were included, the response to treatment diminished.

Number treated	163
Marked improvement	40
Moderate improvement	80
Slight improvement	8
No improvement	35
Discharged	42

The paranoid aggressive attitude of the chronic schizophrenic is favorably influenced by PET. In the treatment situation the therapist comes to grips with the patient's hostility and channelizes it toward himself. This represents a negative form of contact employed by the therapist as the basis for the development of a socially-constructive goal. The patient almost invariably denies that he is hostile, acts out his friendliness, and verbalizes his good attitude and intentions. Subsequently a number of these patients show a change in their behavior and in their general attitude toward hospital personnel. Their friendliness toward the doctor who treated them is striking. Patients who were previously withdrawn showed marked awareness of the doctor at a distance and were quick to hail him with a friendly gesture. Patients who are domineering to those about them become much less so, and accept the restrictions of the environment with greater equanimity.

As one employs this modality with this type of aggressive patient, one becomes increasingly confident that the response of this type of paranoid patient will be favorable. The first reaction of the casual observer might be that such patients would resent this therapy, but more thorough observation of what actually takes place will completely dissipate this *a priori* supposition.

Some very severe problems of institutional adjustment with whom all other forms of treatment failed, were favorably influenced by this modification of electric therapy. For example, a case of paranoid dementia præcox who had had extensive electric shock treatment, deep insulin, and two lobotomies, continued to remain on a back ward for the most part. She actively hallucinated and was vituperative and antagonistic. With the use of PET, it was

possible to bring about a change in her attitude. Her active response to auditory hallucinations diminished. It was possible to place her on a convalescent ward and she eventually left the hospital. She still had marked schizophrenic residuals but it was possible for her husband to supervise her at home, with weekly visits to the hospital for treatment. During these treatment sessions, she was pleasant. She verbalized her intention to co-operate and her appreciation of the way this form of treatment helped her. This case is an example of some of the improvements in adjustment brought about by this therapy, although the basic illness still remained. A number of patients were socialized at home, with weekly visits to the hospital for PET. This was especially valuable with patients whose hostile attitudes toward their relatives made adjustment difficult. The psychodynamic modality gave the doctor an effective means of influencing the patient's attitude toward his relatives and of relieving the family of the intolerable pressure of the patient's persisting hostility.

Striking cases were encountered. For example, one patient with paranoid dementia præcox who had lived on a chronic disturbed ward for 26 years—noisy, restless, and actively responding to auditory hallucinations—showed a marked amelioration of all these symptoms after five PET sessions and was able to socialize on a convalescent ward.

The rigid, withdrawn chronic schizophrenic responded to some extent, but much less so. The emotionally-flattened old cases of hebephrenia were the least responsive.

PARANOID CONDITIONS AND PARANOID REACTIONS IN INVOLUTIONAL PSYCHOSES

Number treated	32
Marked improvement	24
Moderate improvement	4
Slight improvement	4
Discharged	22

The diagnosis of paranoid condition is rather anomalous. Some patients so diagnosed are actually cases of paranoid dementia præcox. Others belong more properly among the involutional psychoses. The basic, commonly-accepted differential depends upon the degree of the integrity of the personality—with a minimum of distortion and of bizarre, fantastic, delusional productions. The aggressive, hostile attitude of this type of paranoid patient was ap-

preciably influenced by the psychodynamic modality. A preceding course of eight to 10 orthodox electric shock treatments was found to be an adequate preparatory setting for the administration of psychodynamic electric therapy. In some of these cases, four to six PET sessions sufficed to bring about a satisfactory clinical change. The contrast between the relative failure to respond to electric shock treatment and the prompt response to PET, was frequently striking.

Involutional psychoses, paranoid type, responded very favorably to psychodynamic electric therapy. The writer's experience with orthodox electric shock treatment in these cases has been very unfavorable, so that the rather marked response to PET was in striking contrast. A rather typical involutional paranoid patient had very fixed delusional paranoid ideas, and failed to show any improvement following extensive electric shock treatment and deep insulin therapy. She showed rapid response to PET, progressively improved, was in a good state of remission when she left the hospital, and has continued to remain well for several months.

Some of the responses of this type of patient to PET have been unbelievably rapid and have required a minimum amount of therapy. For example, one man who was actively hallucinating and who had bizarre delusional paranoid ideas, had failed to respond to extensive electric shock treatment. After one PET session, the pathological mental state disappeared and he seemed quite well. He left the hospital in a few weeks, and has remained well for a number of months. A case of this kind certainly raises the question of the basic causes of mental illness. Obviously, the abnormal mental content and hallucinatory material were related to unassimilated complexes and included infantile and early childhood conditioning which were repressed and never resolved. These early forces gave shape to the abnormal mental content, but a direct environmental stimulation so strengthened the *person* and so invigorated his contact with his environment, that this abnormal mental content again became part of unconscious mental processes which no longer hindered his ability to adjust. The essential feature of the illness was a weakening of environmental influence upon the person, and not the form of the abnormal mental content.

One patient with a senile psychosis, paranoid type, was treated with PET, showed marked improvement, and was discharged.

A very malignant case of involutional psychosis, paranoid type, will illustrate the way in which electric shock treatment, deep insulin therapy, and the psychodynamic modification of electric shock, may be employed:

This 58-year-old woman had been mentally ill, with remissions and exacerbations, over a period of four years. The initial phases of her illness, judging from the history, were those of a rather typical depression with marked anxiety, agitation, and a train of depressive ideas. She had several such depressive periods which responded favorably to electric shock treatment. In the last two years of her illness there had been a decided change, with the development of a suspicious, antagonistic attitude and marked paranoid delusional ideas. During this period, the response to electric shock was no longer favorable.

When she was first seen by the writer, she expressed a number of fantastic ideas and showed a number of regressive features. She also blocked, became rigid, and remained relatively motionless and somewhat cataleptic. The whole picture was quite schizophreniform. Her behavior was very bizarre. She would speak as follows: "The baby came out of the sea by mail." When one followed the train of associations related to this bizarre statement, it was discovered that she had been expecting a letter from her son. Apparently in her dereistic thinking the symbol became transposed into the birth of her son. One inferred that she actually had some sort of creative relationship as though she were again experiencing childbirth.

She failed to respond favorably to orthodox electric shock treatment but she did respond to psychodynamic electric therapy. In the treatment sessions she showed considerable affect and promised to co-operate and to make an effort to get along with those about her. The follow-through from the treatment sessions was not, however, satisfactory. She was then placed on sub-coma insulin and continued to receive almost daily administrations of PET. One very interesting period of psychodynamic electric therapy revolved about the depth of her loss of contact with her environment. Though she could name the days of the week in succession, she did not respond accurately when she was asked to name the third day, the fifth, or any specified day. She was taught patiently every day, but she continued to fail to respond to this simple problem of orientation.

The therapist worked on the assumption that the primary illness did not lie in the paranoid attitude, the fantastic delusional ideas, or the rigid cataleptic phenomena, but lay rather in the loss of that type of mental contact, that quality of effort, which is necessary if one is to shoulder the burden of meeting one's responsibilities. There was a basic loss of the ability to concentrate and attend to a particular goal and to make some effort to meet the demands of the environment. In this particular group of sessions, the doctor was presenting to the patient a very simple goal, an accurate orientation to the days of the week. The true measure of the profundity of her illness lay in the simplicity of the goal which she negativistically rejected and the persistence of her rejection in the face of the patient perseverance of the teaching effort. Psychodynamic electric therapy added force to the environmental pressure, and after two or three weeks, she suddenly showed a perfect orientation to time and to the days of the week. A measure of clinical improvement accompanied the improvement shown in the treatment sessions.

This patient was seen in private practice, and the course of subcoma insulin was carried out at a general hospital. She was then transferred to a nursing home and continued to receive electric shock and PET from time to time when some problem of negativistic hostility arose. The patient's love for her husband was a very powerful, constructive socializing force which gave effective support to the doctor in therapy and to his insistence that she must co-operate. The character of her symptomatology then changed. For a short period, she showed the rather typical anxiety and depression of the benign type seen in involutionally-depressed patients. At this time, one electric shock treatment brought about a remission of symptoms.

The patient continued to improve and eventually became stabilized on a fairly good social level. There were still residual defects of lack of insight with some rigidity of affect, but the social level of adjustment was rather good. It was evident that ordinary electric shock treatment failed to influence the schizophrenic pattern of symptoms, while psychodynamic electric therapy made it possible to contact the patient when she was otherwise inaccessible.

A certain number of manic patients improve under electric shock treatment but show residual defects. Very commonly they continue to be somewhat aggressive, irritable, restless, and hyper-

ACUTE MANICS

Number treated	15
Marked improvement	13
Moderate improvement	1
Slight improvement	1
Discharged	13

active. Under PET it is possible to slow them down, to inspire them with more respect for authority, and to reintroduce a quality of restraint.

One patient of this type was grandiose and hyperactive. She called herself a queen and gave commands to the other patients. She developed a good remission following electric shock treatment but then relapsed. In psychodynamic electric therapy sessions it was possible to get her to verbalize her intention to control her hyperactive over-talkative tendencies. Her general behavior improved and she made a good remission. A sensitization of the patient of this type to his tendency to emotional imbalance with its explosive, impulsive release was one of the goals in the utilization of PET. One gained the impression that it was more effective in stabilizing such patients than additional electric shock treatments.

Although PET was occasionally used in depressed cases, these cases responded so well to customary electric shock treatment that PET played but a minimal role.

CHRONIC MANICS

Number treated	2
Marked improvement	2
Discharged	1

Two chronic manics were given PET and both responded favorably. They had had repeated courses of electric shock treatment without response. One of these cases was especially interesting. She was 28 years old and had been in the hospital for a number of years. She had had extended electric shock treatment and a lobotomy. At the time psychodynamic electric therapy was instituted with her, she was in a state of acute excitement, had been progressively losing weight, and was severely emaciated. Immediately after PET was begun, her acute excitement disappeared and it was possible to place her on a convalescent ward. She progressively improved and reached a good level of institutional adjustment in a relatively short time.

PSYCHOPATHIC PERSONALITY

Number treated	24
Marked improvement	22
Moderate improvement	1
Slight improvement	1
Discharged	22

A number of cases of psychopathic personality were sent to the mental hospital from boys' and girls' training schools and from prison. The chief reason for transferring them was that they had become incorrigible, antagonistic, rebellious, and acutely un-co-operative. This rebellious, anti-social attitude was readily modified by psychodynamic electric therapy. For example, a young man of 22 was sent to the hospital because of his incorrigible, combative attitude. He threatened to kill the various members of the hospital staff, but under PET all of his hostility vanished and he became friendly, co-operative, and pleasant. He adjusted well on the ward, and his whole attitude changed. He was returned to prison in a few weeks and made a satisfactory intramural adjustment there. Certainly we have had no other effective approach to this type of individual. Various punitive measures have utterly failed. That PET is not a punitive measure is shown by its effectiveness in individuals with whom all punitive measures previously failed. It is surprising how well the psychopath accepts PET as a therapeutic measure which is helpful and for which he is grateful.

BEHAVIOR DISORDERS IN MENTAL DEFECTIVES AND EPILEPTICS

Mental Defectives		*Epileptics*	
Number treated	3	Number treated	4
Marked improvement	3	Marked improvement	3
Discharged	3	No improvement	1
		Discharged	1

Behavior disorders in mental defectives and mental disturbances of a rather nondescript type with vaguely-defined paranoid ideas, irritability, unco-operativeness, and antagonism, yielded rather well to PET. In these child-like individuals the fear of the treatment motivated them to develop adequate respect for authority, and re-established their relationship to their parents or other relatives who supervised them. Behavior disorders in epileptics also responded rather favorably to PET.

PSYCHONEUROTICS

Number treated	7
Marked improvement	5
Moderate improvement	1
Slight improvement	1
Discharged	6

A small number of psychoneurotics received PET, with favorable clinical results. The psychoneurotic who has been committed to a mental hospital is, however, an entirely different problem from the extramural psychoneurotic seen in private practice. The committed patient more readily accepts and less readily questions treatment procedures. The attitude of the committed psychoneurotic is more conducive to the successful administration of psychodynamic electric therapy.

One young man of 18 was sent from the boys' training school with a mental picture of anxiety, depression, and marked guilt reactions. His guilt largely concerned itself with his masturbatory activities. He had been sent to the training school because of his anti-social behavior which included stealing and a failure to adjust economically. In addition to the psychoneurotic picture, he showed the characteristic rebellious, un-co-operative attitude of the psychopath. He was not responsive to individual psychotherapy and showed no improvement after electric shock treatment. He responded promptly to the psychodynamic modality. The psychoneurotic picture disappeared. He became co-operative, friendly, and responsive to help. He was returned to the training school where he continued to adjust well, and at last reports he was getting along well in the community.

One patient with hysterical catalepsy promptly responded to the psychodynamic modality. The use of PET in hysterical manifestations requires further study.

ALCOHOLICS

We have so little effective active therapy in chronic alcoholism that any effective approach which offers possibilities is of value. For this reason, PET was employed as a means of conditioning alcoholics, and its usefulness was explored. No alcoholic had PET unless he consented to the treatment. In the treatment sessions, the therapist compared the painfulness of the therapy with the disagreeable effects of alcoholism. He then asked the patient if he wanted a drink of various types of liquor and stimulated the

patient as he mentioned each variety. Some successes were obtained with this form of treatment, but on the whole one gained the impression that the treatment was not very effective as a deterrent against alcoholism. Not enough cases were treated for a sufficient period of time to draw any conclusions.

Use of "Psychodynamic Electrotherapy" in Private Practice

It is apparent that the PET modality is much more suited to institutional practice than to private practice. Patients sent to a mental hospital are more severely ill than those seen in private practice, and the question of their consent to the treatment is not so significant. Since the treatment is rather unpleasant, the patient in private practice—who has the decision to make—may decide against it. There are, however, some indications for the use of psychodynamic electric therapy in private practice. The severely ill patient who is not committed and is treated at a general hospital may have PET. The question of the patient's consent does not arise. A case of this type was described earlier in this paper.

An example of a different type of patient treated with this modality in private practice is that of a 20-year-old man who complained that for the past five months people had been staring at him and laughing at him. He felt markedly self-conscious and apprehensive and could not go out alone. He was accompanied to the doctor's office by an elderly friend. Although this picture suggests schizophrenia, the patient showed so much realization that these ideas were the product of his imagination, and showed so much good contact with his environment and his own emotional needs, that one was inclined to look upon his illness as psychoneurotic. During the PET session, the doctor emphasized the need for the patient to become more stoical and less fearful of the gaze of other people. The doctor encouraged this patient to develop a "don't-give-a-damn-what-you-think" attitude. The patient acted out this aggressiveness and verbalized his feeling that he could meet the gaze of other people with equanimity. After one treatment session, he went to a party by himself, enjoyed himself, and the next day came to the doctor's office alone. He was joyful, cheerful, and confident. He felt that he had achieved a new outlook on life, that he had been silly, and that he was no longer afraid of the future. He received one more treatment, and thereafter

stabilized and has continued to make a good adjustment for some months.

A manic patient who regularly developed mild manic exacerbations about once a month, was treated as an out-patient in a nursing home. One or two electric shock treatments would stabilize her, but she developed a hateful, malicious, spiteful attitude. She would lie, gossip, and create an impossible situation for the home in which she resided. Orthodox electric shock treatment did not modify the psychopathology, but one PET session transformed her. In the treatment session, the doctor apologized for finding it necessary to hurt her. He pointed out to her that her own behavior was alienating everyone in her vicinity. It was his desire to assist her to become again the sweet individual he knew her to be. The type of aggressive, hostile attitude developed by this patient is one of the residuals which readily yield to psychodynamic electric therapy.

There is a place for this form of therapy in private practice, but obviously one must carefully select one's patients, and must depend more than in hospital practice on the attitude of the patient and on his consent to the treatment. One should emphasize to the private patient how unpleasant this form of treatment is, but if the patient is willing to take this form of therapy, there does exist a good chance that the doctor can use this tool to the patient's advantage.

General Discussion

Psychodynamic electric therapy, over a period of a year, has amply demonstrated its practical value. It became an integral part of the total shock treatment picture for the acutely ill mentally, and in addition made treatment possible in cases for whom, otherwise, only custodial care was available. The psychodynamic modality is so harmless physically that it can be repeated indefinitely as an aid to other forms of treatment. In a number of malignant cases of schizophrenia, slight responses to therapy were gradually augmented over a period of weeks and months so that eventually appreciable clinical improvement was secured. This was very important, not only from the standpoint of the clinical improvement, but also because the morale of doctors, nurses, and attendants became geared to the idea of treatment in all cases.

The attitude of futility and nihilism so indigenous to institutional practice was almost completely dissipated.

One of the questions that arises is that of the profundity of the change brought about by this form of treatment. The period of treatment is so short, the response so rapid in many cases, that one may regard the whole procedure as bringing about superficial changes. Psychiatry at the present time is in the grip of concepts of "depth psychology" aiming at profound deep-seated etiologic factors for which only appropriate "submarine techniques" will suffice. Psychodynamic electric therapy may be thought of as a surface approach, contacting the person directly. In a case of involutional psychosis of the paranoid type where the patient is obstreperous, aggressive, has paranoid delusional ideas, and may even hallucinate, PET may bring about a subsidence of all these pathologic mental phenomena.

The patient may make a good social adjustment, but actually, may have no insight, may still have a tendency to hallucinate, and may still harbor the delusional ideas. The mental change may be superficial and the essential features of the illness may remain. But, as a result of treatment, the patient becomes much less responsive to these psychopathologic tendencies, has more respect for the environment, and shows more consideration for the members of his family. A type of practical insight is brought about which makes it possible for the patient to adjust at home. Certainly "superficial" changes of this kind which are associated with a desirable clinical improvement are more worth-while medical goals than "profound" changes which cannot be brought about and which do not influence the clinical picture. One may well question the term *superficial*. The changes brought about by digitalis in relieving the decompensation in heart disease are equally superficial.

There is a danger of confusing surface phenomena with superficiality. Medical practice primarily deals with surface phenomena, with observable presenting symptoms. The trend in psychiatry to think of this clinical material as superficial is not in accord with good medical practice. Our ignorance concerning observable phenomena in the mentally ill is so abysmal that we can well afford to devote the major portion of our time and effort to an at-

tempt to understand what is actually taking place, without bothering too much about any omission of that which is not observable, not measurable, and is only speculative.

A difficult psychological hurdle for the therapist using PET is the painfulness of the treatment. We are accustomed to think of pain and suffering as reaction patterns which we make every effort to prevent or to lessen. Yet, in this treatment modality, we deliberately introduce pain and suffering as a means of securing desirable mental changes. The painfulness of the treatment is the psychological tool whose skillful use brings about improved mental function. As one employs this modality, it is necessary that one adopt an objective, empirical attitude and constantly evaluate the influence of the treatment stimulus on the person treated.

The therapist using this modality needs a specific orientation to the application of a painful stimulus and may well consider the fact that in our everyday lives, all of us are constantly facing innumerable problems, disappointments, frustrations, and dissatisfactions. Our lives are filled with extremely difficult and unpleasant experiences which engulf us in emotional tensions. The problem of living normally is the problem of securing some degree of equilibrium with the disturbing, pain-laden forces. It seems apparent, therefore, that a certain quality of stoicism, fortitude, and ability to endure pain is a fundamental ingredient of the "normal" person, without which normal adjustment would be impossible. The individual who becomes pathologically depressed has lost that quality of stoical endurance and is overwhelmed by the depressive affect and the train of depressive ideas. If one were to speculate psycho-physiologically, one might assume that the quality of stoicism in the *person* represents a resistance factor to the emotional impact of depressive ideas which prevents the overwhelming bombardment of the sympathetic nervous system.

There may be a similar loss of this stoical quality of the person in the presence of anxiety and panic. The presence of this quality of stoicism enables the individual to continue to apply himself to his social routines and obligations with some limitation of the affect and the associated train of ideas. The maintenance of social routine and responsibilities implies a primary contact with the environment and a dominance of this environmental influence.

The fact that an individual can maintain his social routines and keep up his responsibilities in the face of severe anxiety and de-

pression means that although the person feels very bad, he is able to endure the unpleasant feeling and maintain the flow of his energy toward socially-oriented goals. *One may therefore think of the basic factor in mental health as depending upon the stoical endurance of emotional pain and not upon insight into the various problems, frustrations, and disappointments associated with that painful emotional state.* The organization of the mentally "healthy" person includes a means of assimilating and incorporating painful stimulation. The essential feature of mental health or disease will depend upon the assimilation and incorporation of painful stimulation. The successful assimilation and incorporation within the person of an ability to deal with painful stimulation will be clinically evident as a quality of stoicism. The therapist who looks upon this quality as the essential feature of normality will be enabled to employ PET intelligently.

One may think of mental illness as arising primarily in relation to emotional pain. Each individual develops his own pattern of reaction to pain. One individual may have a predominating pattern of depression; another that of anxiety or panic; still others may react with hostility, while some may develop a hysterical compensation with euphoria. In the course of administering psychodynamic electric therapy, all these various patterns were encountered and were relatively characteristic for each individual. The reaction with panic was an especially striking feature in the most malignant schizophrenics who were resistant to treatment. They developed delirioid reactions and would be out of contact, so that no constructive use of PET was possible. This hair-trigger panic reaction might well be considered the essential psychopathological mechanism. There was no resistance on the part of the *person* to the impact of fear.

The administration of this modification of electric therapy requires a special type of psychobiological orientation on the part of the therapist. His attention must be centered on the negative symptomatology. Hughlings Jackson extensively discussed negative and positive symptomatology in nervous disease and pointed out that the negative symptoms are primarily related to the pathology and structural changes. The positive symptomatology represents the distorted over-active function of the remaining healthy tissue. This is equally true of mental illness. The loss of normal function is the essential psychopathology. The delusions, hallu-

cinations, rigidity, and cataleptic phenomena represent the distorted over-active function which remains. Elaborations of this interpretation may be found in the bibliography at the end of this paper.

In administering psychodynamic electric therapy, the goal is always given in terms of the negative symptomatology; and, in order to set the goal, the therapist must develop this psychobiological orientation. One is primarily interested in the personality-functioning which is lost. For example, the mentally ill patient who is withdrawn, rigid and unresponsive has lost the normal motivation to make an effort, to win approval, and to aim at socially-approved goals of activity. In administering PET to such a patient, one constantly aims at a return of the contact which is lost, at arousing a response to motivation which is no longer present, and at a reinforcement of goals. The therapist aims at a restoration to the person of a willingness to make an effort and to shoulder responsibility. The loss of these socializing functions of the person is the most important index of the mental illness.

Summary

"Psychodynamic electrotherapy" (PET), although it employs a physical agent, is primarily a form of psychotherapy. It is therefore primarily an adjunct to the other forms of shock treatment, although occasionally in isolated cases some striking results were obtained with this form of therapy alone.

It was valuable in acute schizophrenics who showed residual defects after treatment with the other shock procedures.

It has a definite place in treating chronic schizophrenics. Patients presenting severe problems in institutional management showed considerable improvement. Hostility, both actively and passively expressed, responded to PET. Flattened, deteriorated, old cases of schizophrenia were relatively unresponsive.

This form of treatment was very effective in the involutional paranoid psychoses.

The rebellious, un-co-operative attitude of the psychopath yielded promptly to this treatment.

Hostility reactions in all forms of mental illness, acute and chronic, readily responded to PET.

This treatment was useful in stabilizing manic patients who had failed to respond adequately to electric shock treatment.

The small number of psychoneurotics given this treatment responded favorably on the whole. The one case of hysterical catalepsy responded, as did the one case of psychoneurosis treated in private practice.

Behavior disorders, periods of excitement and nondescript paranoid reactions in the mental defectives and epileptics treated, responded favorably.

The effects of PET in alcoholism are inconclusive. It had some value and occasionally an alcoholic benefited considerably.

The administration of PET requires a specific psychobiological orientation on the part of the therapist.

The use of a painful modality requires an orientation to the place of stoicism in the make-up of a person. The therapist constantly aims at synthesizing in the person his ability to assimilate the painful stimulus and reintegrate his capacity for dealing with the disturbing affective states.

The use of psychodynamic electric therapy requires an orientation to the negative symptomatology of mental disease. This orientation requires the triad of person, affect, and environmental stimulation. The therapist constantly aims at a reorientation of the person and a redirection of the affect.

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PSYCHIATRIC PROBLEMS OF THE PUERPERIUM FROM THE STANDPOINT OF PROPHYLAXIS*

BY LOUIS LINN, M. D., AND PHILLIP POLATIN, M. D.

A. The Extent and Nature of the Problem

It is a well-known fact that childbirth plays an important role in the development of mental disease. According to several investigators,[1, 2, 3, 4] close to 10 per cent of all female admissions to psychiatric hospitals are the result of childbirth. The patients requiring hospitalization naturally are the more seriously ill. Many milder cases are treated on an outpatient basis and do not require admission to a hospital. Of 123 female patients seen privately (L. L.) over a period of two years, 9 per cent became ill after childbirth. A not inconsiderable number of women, who develop mental symptoms following childbirth, do not come to the attention of psychiatrists at all. Many women have transitory melancholic reactions postpartum while still in the hospital; others develop feelings of anxiety or inadequacy on return to their homes. These subclinical reactions, which are barely perceptible to others, have immediate psychiatric significance for motherhood and may even presage more serious future illness. An additional point is the fact that other children than the new-born, who are so dependent on their mothers for their emotional well-being, can be seriously affected by the illness of the mother. The psychiatric disturbances of the puerperium are of great importance and present a fairly urgent problem in prophylaxis.

The object of this paper is to present what appears to the writers to be a rational program of prophylaxis. It is based primarily upon the intensive study of 22 patients observed at the New York State Psychiatric Institute, in private practice over a period of two years, and upon information gathered from available literature.

B. Pregnancy as a Psychosomatic Condition

Psychosomatic medicine has been defined[5] as "an operational approach to the theory and practice of medicine in which the structure and function of the psychic apparatus are dealt with as a variable in health and disease, just as, for example, are physiology

*Read before the section on psychopathology at the 105th annual session of the American Psychiatric Association, Montreal, May 27, 1949.

and pathology." In other words, after the obstetrician has ascertained the local gynecologic status of his patient, the cardiorenal status, the hemotologic status, etc., it behooves him to ascertain, and correct if necessary, the psychic status of his patient. This latter task requires special knowledge and much time. The limitations of space forbid lengthy discussion of history-taking from a psychosomatic point of view. Fortunately, information in this regard is readily available.[6] The contributions of Deutsch[7] on the nature of the psychic apparatus of the patient is of basic importance to the obstetrician. Here the writers wish to call to the attention of the obstetrician fundamental psychological principles involved, and to point out certain landmarks which should alert him to the presence of an emergency calling for a psychiatrist.

C. Which Patients Require Psychiatric Treatment During the Prenatal Period?

The mechanism of labor itself is a complicated one. The autonomic nervous system co-ordinates the activities of the three muscular layers of the uterus according to a precise pattern in each of the stages of labor. The activities of the voluntary muscular system and the respiratory apparatus must be integrated with the contractions of the uterus and the musculature of the cervix, which in its turn must be capable of unobstructed progressive relaxation. When all the component parts of this labor mechanism cooperate as they should, then the effectiveness of the muscular action is at a maximum and the associated physical discomfort at a minimum, and the entire experience can be a richly satisfying one to the expectant mother.[7, 8] From a psychiatric point of view the greatest enemy of this mechanism is anxiety.[8] In response to anxiety, a cervix which should relax remains contracted; voluntary innervation which should be held in abeyance comes into action prematurely; and the entire delicate mechanism is thrown out of gear. Labor becomes prolonged and painful. To the extent that anxieties concerning the elementary facts of labor can be resolved by reassurance, all women approaching childbirth can be benefited. In this sense, all women need psychotherapy pre-natally. However, this factor by itself is only partially and indirectly relevant to the present problem.

Contrary to prevalent opinion, toxic-exhaustive factors play only a minor role in the over-all picture of puerperal psychosis. Indi-

vidual instances have been cited in the literature[9, 10, 11] in which these factors seemed to be of great importance. In a group of 220 cases, Smalldon[3] found that in only 3.6 per cent were toxic-exhaustive factors of importance. In the writers' own series of 22 cases there were only two women in whom toxic factors figured significantly in the onset of their illnesses. A detailed study of one of these two cases made it clear that the toxic factor was in the nature of a last straw and that other factors were much more important.

D. The Psychiatric Disorders of the Puerperium Begin Before Pregnancy

The injury from which these patients suffer is not physical but psychological. The all-important trauma occurs not during parturition, but many years before that.[12] If this is true we should be able to select these women before childbirth and possibly do something to avert a threatened breakdown. The question, then, arises, what are the characteristics of the susceptible woman? To begin with, the basic personality is an abnormal one. This was emphasized repeatedly by Zilboorg.[1, 12] He pointed out that these patients were "schizoid" individuals. That is to say, they were apt to be shy, withdrawn people who reacted poorly to others and were inclined to be stubborn and negativistic. These women showed disturbances in sexuality, particularly frigidity. Characteristically, they had few contacts with men pre-maritally; they were inclined to marry late, usually after a long courtship. Smalldon[3] was able to corroborate this general picture. In the writers' series of 22 cases, they found a more diversified background. In addition to the foregoing schizoid picture they encountered in their patients other psychiatric manifestations such as depressive tendencies, hysterical phenomena, phobias, hypochondriasis and enuresis. These neurotic phenomena were clearly present in all except two of their patients. Only two others in this same series seemed genuinely content with their role as housewives. The rest expressed varying degrees of dissatisfaction with the fact that they were women, either in so many words or in their choices of occupations or in their general interests. This tendency to masculine identification, present so frequently in these patients, correlates with the homosexual drives described by Zilboorg in the pa-

tients he psychoanalyzed.[1] Probably the most striking feature encountered by the writers in their group of cases was the presence of episodes of incapacitating psychiatric disease prior to the postpartum illness. Eight of the 22 patients had previous histories of severe psychotic depressions lasting several months. Three of these had occurred following previous pregnancies. One had had an acute phobic reaction which started after a previous childbirth, then subsided after three years, only to recur after a second pregnancy five years after the first.

It is thus possible to identify the susceptible woman. Her basic personality is an abnormal one. She is rarely satisfied with the role of housewife. The chances are close to 50 per cent (in the present series) that she has had an episode of incapacitating psychiatric illness prior to her present pregnancy. A pregnant woman who presents the foregoing characteristics should be regarded as a potential psychiatric patient and intensive psychiatric treatment should be strongly recommended during the pre-natal period.

E. The Woman Who Is Glad She Is Pregnant

It is remarkable how rarely the writers encountered among their group of patients dissatisfaction with the pregnancy. As a matter of fact not one of these patients had expressed the wish to have the pregnancy interrupted. On the contrary, questioning elicited expressions of great satisfaction. Frequently the pregnancy had been planned, and in one case was actively desired for several years before it was finally achieved. Many of the patients expressed a sense of well-being during the pregnancy. Only one was physically uncomfortable. She had severe vomiting during the first trimester and many somatic complaints thereafter. However, even she was glad she was pregnant and approached active labor in a happy frame of mind.

These observations suggest the conclusion that there are many reasons why a woman may be glad she is pregnant; but not all of them are acceptable. Two of the writers' patients became pregnant because doctors told them that having a child would "cure" their nervousness. The point that the writers wish to make is that an apparently favorable attitude toward the pregnancy may be deceptive and should not militate against psychotherapy if the foregoing criteria are present.

F. The "Maternity Blues"

Many women display transitory episodes of tearfulness during the postpartum period. This is such a common occurrence that it is sometimes flippantly referred to by patients as "maternity blues." Obstetricians with whom the writers have discussed the problem have verified the fact that this occurs frequently, and they are inclined not to take it too seriously. From the writers' own data, they are not prepared to state how serious this phenomenon really is, but they feel that it deserves controlled study. The writers recently had occasion to follow, during the postpartum period in the hospital, three such patients who had the "blues" lasting one or more days. When sent home they appeared well from a psychiatric point of view. Two developed definite symptoms requiring psychiatric treatment within a year. The seriousness of "maternity blues" must be gauged by the presence of the additional psychiatric criteria alluded to previously. When indicated, observation for possible psychiatric complications postpartum should be maintained for many months following the actual birth of the child.

G. Boy Child or Girl?

In view of all the literature on psychiatric complications after childbirth it is remarkable how little attention has been paid to the role of the sex of the child in the illness of the mother. It has been the impression of psychiatrists, questioned on the subject, that mothers of male children are more frequently involved in postpartum illness than are mothers of female. In the writers' own small series, 11 of the babies were girls, eight were boys, and in three cases the sex of the child was not recorded. Zilboorg[11] stated that the birth of a girl child, by promoting identification in the mother with the child, is less apt to be followed by psychiatric disease. Illness is more apt to follow the birth of a boy and, when it does occur, is apt to be a depression. In women in whom there is a more thoroughgoing rejection of femininity, the femaleness of the child does not promote maternal identification. On the contrary the child becomes the object of even more violent rejection; and the resulting illness is apt to be a more malignant, schizophrenic process.

Apropos of this theory, the following report may be of interest. Three of the writers' patients were sisters. One had two girls

and a boy in that order. She delivered the girls without psychiatric mishap but became depressed after the birth of the boy. The second sister had a boy and a girl. She became depressed after the birth of the boy but not after the birth of the girl. The third sister had two boys and developed a depression following both pregnancies. All of these cases were treated symptomatically, not psychoanalytically; and, as a result, the writers do not have corroborating psychological material. The material in the present series of patients is not consistent in this matter. That other psychodynamic mechanisms may operate is indicated in one of the women to whom the birth of a girl came as a great disappointment and seemed to contribute significantly to the appearance of a moderately severe depression. In this case the patient felt that she had disappointed her father who wanted her to have a boy. While one cannot draw statistical conclusions from the writers' small group of cases, it may be stated as a fact that benign depressive reactions with good prognosis can occur after the birth of a girl.

II. The Paradox of Obstetrical Analgesia

So much has been written about the "agony" of childbirth that one is likely to lose sight of the positive aspects of this experience. Helene Deutsch[13a] described it as "the greatest and most gratifying experience of woman, perhaps of human beings," and added that it is capable of creating[13b] "a feeling of triumph and endows the first moment of motherhood with real ecstasy—the first foundation stone, perhaps even a reservoir from which springs the gradually developing love for the child." Most women accept obstetrical analgesia because they have been taught that the childbirth experience is too dreadful for the modern woman to endure.

The whole question may be of real psychiatric significance. One of the present cases was very instructive in this regard. This woman, 24 years of age at the time of delivery, was a neurotic individual all her life. She was shy and fearful from earliest childhood, obsessed with inferiority feelings and given to anorexia and vomiting under emotional stress. When she went into labor her husband was in the army and could not be with her. Knowing her nervousness and her intolerance of pain, the family asked the obstetrician to spare her as much as possible. As a result of these facts and because labor was progressing somewhat slowly, she was

delivered by cesarean section. On coming out of the anesthetic and learning that she had had been delivered of a baby girl by the cesarean section, her immediate reaction was a feeling of revulsion directed at herself; and the thought she had was this, "I am no good at all as a woman. I can't even deliver my own babies." In the postpartum period she was mildly depressed and, during the months which followed her return from the hospital, there emerged an agarophobia of gradually increasing intensity which confined her completely to her home for over a year. In psychotherapy it was brought out that she envied her mother, who was a charming, socially successful woman, and her older sister who was like the mother. Her inferiority feelings expressed themselves in the thought, "I cannot succeed as an adult woman." Her pregnancy seemed to belie this idea; and, during all the months preceding parturition, she had a sense of well-being exceeding anything she had experienced in the past. Childbirth might have been a beneficial turning point in her emotional development. "But even in this situation," she thought, "I cannot do as my mother and sister did before me." The cesarean was a *coup de grace,* as it were, to her ambitions as a woman.

In the foregoing case, there is an example of the psychologically deleterious effect of obstetrical analgesia. This woman apparently needed the experience of childbirth to augment and replenish her narcissistic libido.

Rejection of the offspring by its mother is of great importance in the psychopathology of postpartum mental illness.[19] In those cases in the writers' series where they were able to get at the psychodynamics, rejection of the child, consciously or unconsciously, was invariably present, giving rise to guilt feelings, anxiety, depression, and denial of reality.

An additional effect of postpartum mental illness was brought out in a syndrome which the writers have encountered five times during the past few months. Each of these five patients had an only child, and a history of transitory psychosis (four depressions and one acute paranoid schizophrenic psychosis) following the birth of this only child. These psychotic episodes were followed by clear intervals lasting 17 to 20 years. Reactivation of the psychoses occurred in these cases when the only children (now adults) left home to go to college or to get married. The writers say "reactivation" because the second psychotic episodes were almost

identical clinically with the first. The departure of the children in actuality seemed to have reactivated the pattern that dominated the original psychoses: first the wish for the departure of the child, and then all the associated guilt feelings, anxiety and depression.

Thus, one must look as far as the involutional period in order to assess fully the effects of postpartum mental illness. It follows from this that it is a measure of major importance to combat the feeling of rejection and to emphasize the forces which strengthen the bond between the mother and her child. Active conscious participation in the childbirth process by women predisposed to psychiatric illness would seem to be such a prophylactic measure. Deutsch[185] has commented on the frequency with which obstetrical analgesia gives rise in the mother to a feeling of alienation from her child. Probably this is not of great importance in the mother who is psychiatrically sound. However, where a tendency to rejection already exists as part of maternal psychopathology, analgesia may contribute to the mental breakdown of the mother. How significant a role analgesia plays in this regard the writers are not prepared to say.

In the present series of 22 cases, one patient was delivered under spinal (probably caudal) anesthesia, one was delivered by cesarean section under general anesthesia. All the rest of the patients on whom there is information, received obstetrical analgesia in one form or another, usually barbiturates alone or in combination with scopalamine. This by itself is not significant since nearly all women today are delivered under analgesia. The writers intend to pursue this question further and to compare the incidence of puerperal psychiatric complications in women delivered with analgesia and that in women delivered without it. It may be that those women who plead most vehemently for analgesia are the very ones in whom its use demands most caution. Analgesia by itself may aggravate the tendency to illness in the psychiatrically-susceptible woman. Obstetrical analgesia in such women should not be regarded as a substitute for pre-natal psychotherapy. On the contrary, its use enhances the importance of the latter.

The writers are well aware that the ideas presented in the foregoing paragraph demand documentation. They are presented in the spirit of a working hypothesis, as a guide in the accumulation of further data and, ultimately, in the formulation of a more nearly perfect program of prophylaxis.

I. Nursing the Baby

From what has been said before, it would seem to follow, that breast-feeding should be encouraged as a mental hygiene measure for the mother. However, this advice should be given with some reservations. In three of the writers' cases, the inability of the mothers to provide enough milk from their breasts had very traumatic effects. These women reacted with inferiority feelings, and with hostility, toward the child who evoked these feelings. Possibly, failure in the milk supply was in itself an expression of rejection by the mother, although in one of the writers' cases the nursing failure was the result of breast abscess, not lack of milk. It is the writers' feeling, based on these experiences, that in the case of a psychiatrically-susceptible woman, breast-feeding is not to be urged. It need scarcely be said, on the other hand, that this same woman should be encouraged and assisted to assume as active a role as possible in the artificial feeding of her baby.

J. Summary and Conclusions

1. Childbirth plays an important role in the development of mental disease.

2. The woman who is most susceptible to postpartum mental disease is recognizable by the fact that her basic personality is often an abnormal one. She is inclined to be shy, seclusive, stubborn, and negativistic, frigid in her sexual life, and unhappy in her role as a housewife. Most striking of all is the frequency with which overt symptom-formation is encountered in the history, namely, hypochondriasis, hysterical phenomena, phobias, and depression, including actual psychotic breakdown.

3. The first step in prophylaxis is case finding. For this a careful psychiatric history and a psychosomatic point of view are called for on the part of the obstetrician.

4. Susceptible women should be put under psychiatric treatment as soon as they are recognized pre-natally. Treatment should be continued for many months postpartum.

5. The paradox of obstetrical analgesia is discussed. Analgesia by itself may aggravate the tendency to illness in the psychiatrically-susceptible woman. Obstetrical analgesia in such women is not a substitute for pre-natal psychotherapy. On the contrary, its use enhances the importance of the latter.

6. Infant feeding is discussed from the point of view of postpartum mental disease.

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EDITORIAL COMMENT

BACK TO BABEL

When is a door not a door? And what price schizophrenia when it is labeled mixed psychoneurosis, manic-depression, depressed—or even epileptic equivalent?

We have sometimes heard the aim of medicine described—in terms of lengthening the span of life—as back to Methuselah. We sometimes think psychiatry has forgotten Methuselah and gotten back only as far as Babel, where "the Lord did there confound the language of all the earth."

This is preliminary to embarking on a song with a very old refrain. Pending a better suggestion, it might be entitled—to paraphrase a plea which has seen recent political usage—"Don't Shoot the Statistician; He's Doing the Best He Can." The theme is based on the fact that, like a once famous project of Eugene Debs, a good many of our mental hygiene statistics "ain't worth a tinker's dam." It is axiomatic, in cases like this, to reflect that there are liars, worse liars and statisticians; our own contention is that there is little wrong with the statisticians; if they are too often in the habit of obligingly "proving everything" that somebody wants proved, the fault is in the material they are compelled to work with—the statisticians themselves are doing the best they can.

We are thinking here in particular of schizophrenia, which is admittedly hard to diagnose in a certain percentage of cases. There is the hallucinating alcoholic, for example, who discloses—when his acute episode subsides—a fully-developed schizophrenic delusional system; there is the "pseudoneurotic" who proves, as his disorder progresses, to be psychotic, not neurotic; and there is the case of apparently simple depression who develops catatonic features. Diagnoses, of course, are changed; but there have been instances in the past when some such question as a marriage annulment was required to bring about reconsideration.

One notes here too that our concepts of mental disorder are subject to change and that many have never been susceptible to exact definition. We can be certain that schizophrenia is a recognizable—if not always recognized—syndrome; whether it is a specific disease entity can be left for argument elsewhere. But whether it

properly includes, besides the conditions commonly grouped as dementia præcox, non-deteriorating paranoia and other conditions usually referred to as paranoid, is a separate question and one which may be answered in as many ways as there are clinicians.

That this and other questions actually are answered in various ways is plain to anybody with occasion to compare "statistics" from institutions adhering to the approved nomenclature of the American Psychiatric Association. Those in position to survey psychiatric statistics on a national scale report variations which, however well-publicized, can still be only called amazing. The incidence of schizophrenia varies widely in continguous states and often in adjoining hospitals. (We are considering here statistics of dementia præcox, the diagnosis of which may or may not be affected by the somewhat wider concepts implied in "schizophrenia," but which is a term probably accepted by the majority as synonymous.) Geographical, cultural and other factors are not in evidence to explain the discrepancies in the incidence of this disorder. Neither do they explain discrepancies in recovery and discharge rates, and the confusion—which is not entirely caused by the confusion about schizophrenia itself—persists in regard to other epidemiological elements.

It does not seem unreasonable to suppose—in the absence of obvious explanations for such discrepancies—that there are artifacts in their production, that the discrepancies in statistics do not reflect discrepancies in actuality but discrepancies in diagnosis and reporting. Besides failure to correct original wrong diagnoses and disagreement over the conditions to be included under a single diagnosis, we have many persons reporting diagnoses who lack the training for proper determinations. There is also the factor of stubborn intolerance of paper work on the part of many busy clinicians who are less than compulsively meticulous in statistical matters. One notes in all fairness here that the person primarily interested in problems of human behavior, normal and abnormal, is unlikely to be an enthusiastic mathematician; the two interests seldom fit into a single personality.

But virtually all of modern science is, and must be, built upon data which can be expressed in the language of mathematics. We think too many of our medical scientists are tyros in appreciation of mathematics. We do not and should not require the clinician to be a statistician. But we can and should require the clinician to

appreciate the importance of the material he reports to the statistician.

Good statistical studies are necessary for the proper understanding of the problems raised by any illness. In this connection, the problem of schizophrenia is particularly timely and particularly germane. We may take, for example, the important and exhaustive studies which have been under way for some years by the medical geneticist, Franz J. Kallmann, M. D., under the sponsorship of the State of New York. Besides the frequently-raised question of whether conditions reported in such an investigation represent biological inheritance or inheritance of environment, there is the further question of who diagnoses the subjects reported to Dr. Kallmann as schizophrenic. With all his painful research into the accuracy of diagnoses, the answer still must rest on hundreds of individual clinicians.

This difficulty of diagnosis in schizophrenia, with particular reference to the Kallmann work, is commented on in a thoughtful article by Gerard and Siegel in the January issue of this QUARTERLY.* "To begin with," they note (p. 49), "the term 'schizophrenia' lacks specificity. It is not the name of a single definite disease, but rather functions as a title for a number of somewhat similar patterns of maladaptation and characterological tendencies which are not necessarily similar in etiology, prognosis, or nosologic features." In reporting their own case material, 71 patients at Brooklyn (New York) State Hospital, the same authors note (footnote p. 55), "Two cases were diagnosed as schizophrenic by the authors but were classified differently in the hospital records." And there we have it! Who is talking about what anyhow?

The question of schizophrenia has become the more pressing with the introduction of radical surgical methods of treatment. Who decides whether patients to undergo lobotomy are schizophrenic? Without better criteria than we have, what dependence can we place on statistical reports of improvement or recovery of lobotomized schizophrenic patients? One presumes that, because of the greater expense and the greater difficulty of the new topectomy operation, increased care in diagnosis will be undertaken —as it is certainly indicated. But improved statistics from any such motivation as this can cover only a small sector of the vast

*Gerard, Donald M., and Siegel, Joseph: The family background of schizophrenia. PSYCHIAT. QUART., 24:1, 47-73, January 1950.

territory embraced by schizophrenia. Skeptics will still wonder whether the psychotherapist who reports recoveries from purely psychological procedures is reporting on schizophrenia or half a dozen other conditions; shock treatment results will be similarly questionable.

Shock treatment statistics have, in fact, a long history of controversy. We recall one scholarly and carefully-prepared statistical paper on insulin shock treatment which this QUARTERLY refused to publish on the grounds that the hospitals reporting were not reporting the same thing. Several treatment procedures—having in common chiefly the use of insulin—were reported under the single definition of shock treatment; criteria for improvement and recovery were as various; the criteria for diagnosis were subject to the same criticism. This particular difficulty has been aired time and again at conferences of directors, clinical directors and other medical personnel of the New York State Department of Mental Hygiene.

We again emphasize that we are not criticizing our statisticians or their statistical methods. Within the last few years the New York State Department of Mental Hygiene has completely modernized its Bureau of Statistics; a punch card system is now operating to permit more rapid and more accurate tabulation of information than ever before. The statistical bureau is regarded everywhere as a model of its sort.

But tabulations are only as good as the figures on which they are based. The question is where we should start to improve our statistics. A beginning of some sort has been made in remedying the large factor of insufficient personnel which hampered us all in wartime and in the years directly thereafter. The first real progress should come after our training programs have produced better psychiatrists on all treatment and administrative levels. We need to emphasize and re-emphasize, in our work of teaching, the vital significance of accurate observation of facts and accurate recording of them.

The psychiatrist reporting on a mental examination, the resident making a progress report, the psychologist recording test results, must be trained and supervised to the end that all relevant material must not only be elicited scrupulously but must be set

down accurately. Our statistical clerks must be recruited with at least mildly obsessive-compulsive features, and trained with those qualifications in mind.

The heart of the problem lies in the diagnostic process. We think we have indicated sufficient awareness of its difficulties. The responsibility, in most organizations, rests with the clinical director. The necessity for his careful training and experience is obvious; and, for some years, the New York State Department of Mental Hygiene has intensified its work in the training of this important medical officer. We think this training should be expanded and intensified.

It is perfectly true that the affixing of a sometimes doubtful diagnostic label is not the end-all of the clinical conference or staff meeting. In emphasis on diagnosis, we are not neglectful of the fact that everything possible in a patient's case should be evaluated; the psychodynamics, the life situation, and the remote and precipitating reasons for the mental breakdown. But to clarify treatment, to understand individual prognosis, to comprehend the epidemiology of mental disorder, and to compare intelligently the efficacy of treatment methods, our cases must be carefully classified. Imperfect as psychiatric diagnosis is—and we are mindful of certain sweeping and very well-taken criticisms of our standard system—its accuracy in practice is the best measure we have to assure that, when we discuss mental disorder, each of us has some idea of what the other is talking about. Paranoid schizophrenia$_1$ is not paranoid schizophrenia$_2$ as the general semanticists would remind us; but the high order abstraction, paranoid schizophrenia, is the best language-tool available to describe a psychopathological condition which is generally recognizable and is of clinical significance.

Perhaps more time should be devoted to imbuing the clinical director with the importance of the diagnostic function. Perhaps ways can be found to inspire more scrupulous and painstaking work, and to review statistical data sheets more carefully. But it must be recognized that the temperamental set, the life history and the life situation of the clinical director himself are more potent factors than the pains he may take when the individual who is the clinical director comes to "call the cards" in a diagnostic conference. His own problems often determine whether he will cast a given case into the psychoneurotic or the schizophrenic

group—or the diagnosis he will assign to one of those ill-defined cases sometimes described as schizo-affective. Most administrators of psychiatric hospitals have observed this phenomenon.

We cannot and would not argue here that each clinical director should undergo a personal therapeutic analysis. We suspect that, in many, analysis would work no change so far as this problem is concerned. It is the responsibility of the hospital administrator himself to review all apparent diagnostic trends, discuss them with his clinical director, and see—as far as his own personality will admit—that any diagnostic bias is ameliorated. It is also his responsibility, of course, to see that such other concrete steps as may improve the accuracy of reporting also are taken and that the importance of accurate paper work in the progress of medical science be stressed.

If we are to have sound statistics on which to build sound medical progress, the data on which our statistics are built must be accurately determined. We cannot expect the language of mathematics to be intelligible or to lend itself to accurate deductions, if the material we give our mathematicians suggests that it itself is confounded from the languages of all the earth.

"SHOTGUN WEDDING!"

The State of New York has a broad new program covering sex offenses and providing for psychiatric study of sex offenders. It seems that "sex crime" has been recognized for what it is, a public health problem, and that psychiatry is also being recognized for what it is, a public health instrument.

Matters of mental hygiene have been forcing themselves in recent years on the attention of our public health authorities. Suicide is predominantly an emotional problem; psychological factors in causation of accidents have been stressed increasingly by insurance people, motor vehicle authorities and others; and it has been professionally recognized of late that alcoholism and drug addiction are psychiatric problems. More than half of our states have sterilization laws—most of them unwarranted by scientific fact, we may be sure—directed toward the prevention of mental defect and mental disorder. And what we may call the re-discovery of psychosomatic medicine has forced itself on the attention of our public health authorities. Emotional factors in even such "somatic" disorders as tuberculosis have proved too important for anybody to overlook.

There seems to be no good reason for failure of the psychiatrist and the public health physician to co-operate to mutual advantage in the general promotion of health—which is a psychosomatic problem. They can learn much from each other. The public health physician is a specialist in epidemiology, among other things; adequate epidemiological studies on many specific psychiatric disorders have never been made. The scientific method, as understood by the public health physician, can also be applied in salutary fashion to other psychiatric conundrums. From the administrative standpoint, the help of the public health specialist in the control of tuberculosis, dysentery and other infectious disorders in our psychiatric institutions has continued to be most valuable.

We do not anticipate that psychiatrists would receive all the benefits of co-operation; we have some to give, ourselves. The psychiatrist can certainly contribute some understanding of emotional factors in physical illness to the public health physician. He may be able to get medical recognition of the fact that certain forms of suspicion, bigotry and intolerance are contagious mental disorders—this with reference to health education. And in the same field he knows something about propaganda. He may help

in accident prevention; and he certainly can contribute his understanding of psychoneurosis, which is pandemic and is the most common cause of health disability. The psychiatric technique in interviewing and in interpersonal relationships in general should be valuable to anybody dealing with health—personal and public.

The purpose of this discussion is to urge closer co-operation of mental hygiene and public health people. From our own point of view, we have enjoyed contacts with health officers in the past and look forward to them in the future. One cannot, however, anticipate that all will be beer and skittles. We foresee an unavoidable trend toward making epidemiologists into psychiatrists overnight; and, psychiatrists being human, foresee an equally unavoidable trend toward making psychiatrists into epidemiologists overnight. We think we shall have to remind our colleagues that treatment of syphilitic meningo-encephalitis is still a psychiatric matter, and shall have to remind ourselves that treatment of emotional factors in allergy does not solve the problem of susceptibility to pollen. We shall have to bear in mind, too, that just as we should not attempt to take over the burden of physical preventive medicine, so we should combat efforts of health administrators to incorporate mental hygiene institutions in their own departments "to round things out." Such incorporation is in effect in a number of states; it has evidenced notable defects but is an attractive proposal for obsessive-compulsive officials.

Unified public health services sound attractive. The proposal, in fact, is one of those traditionally splendid ideas—the only trouble with which is that they do not work. (The doubtful are hereby referred to the classic uproar created by the navy in what seems to be an eminently-sensible unification of America's armed forces.) One must agree, at the start, that mental hygiene is a matter of public health and that unconscious, emotional factors must be considered in connection with any health problem; for example, we may refer to the emotional resistance to vaccination still encountered occasionally, and to the emotional opposition to medical experimentation with animals.

But the facts over many years have demonstrated that, to administer a mental hygiene department successfully, one must have had experience in administering a hospital for the mentally ill. The inexperienced administrator is engulfed otherwise in a sea of

problems which can be traced to the vagaries of the psychoneurotic and the psychotic. Mental hospital buildings must be planned with direct knowledge of the habits and proclivities of mental patients. Hospital personnel must be trained, food must be bought, clothing and shoes procured, and occupational therapy planned in line with personal professional experience. We think that wise decisions on the higher administrative levels must be based on such experience and on psychiatric training. One concept of mental disorder is that it is an emotional disturbance of reason. We do not believe mental patients can be properly understood or cared for by administrators whose whole scientific training is based on cold, unemotional reasoning.

We are moved to this observation by the fact that an experiment is under way to produce a new hybrid in the way of a public servant—a cross between the psychiatrist and public health physician. He would be an unquestionably useful figure if a way could be found—as a famous consolidator of newspapers used to phrase it—to preserve the best features of both. We are skeptical of the effort, however, except insofar as a public health physician grounded in psychiatry might aid in interpreting psychiatric principles to his colleagues in public health work.

The epidemiologist and psychiatrist are, of necessity, cut from different cloth. Their temperamental sets must lie at different poles. The public health physician, we believe, should be primarily an epidemiologist; and he should be a scientist in the usual sense of the word—as is a chemist, a mathematician or a biologist. That is, he must be objective, must deal with obvious cause and effect, and must make no deductions beyond what scientific observation permits. The psychiatrist has a different task; he must listen objectively to his patient's illogical and unreasonable unconscious; he cannot be offended by crude material and disorderly lack of logic in unconsciously-motivated thinking and behavior; he must be able to identify with his patient and must, of necessity, depend on his intuition, not his reason, for understanding.

We presume we could refer to Jung's psychological types here. The cloth from which some of us are made is not adaptable for the tailoring of a psychiatrist—and neither is the material from which the best psychiatrists are made suitable for the production of the epidemiologist. We feel that all persons practising psychiatry should have preliminary medical training; but we must note that

much of one's initial experience in psychiatry is devoted to the breaking down of the compulsive attitudes, precepts, prejudices and procedures so carefully inculcated in the young physician and so necessary for the practice of physical medicine. In a psychiatric disorder, one does not note symptoms meticulously and fit them into a framework where there is precise diagnosis and specific treatment. One recognizes that the symptoms are real to the patient but that they outline, rather than define, a mental syndrome. And extremely various symptoms may define the same syndrome. In psychiatry, the young doctor not only learns but unlearns.

We do not subscribe whole-heartedly to the view that one grows too old to learn. But as a practical matter, we are convinced that a career of learning according to a single pattern does not facilitate learning according to a different one. For this reason, we may apprehend difficulties if public health physicians begin to practise psychiatry—as we would if psychiatrists began to practise in the public health field.

We think, as another practical matter, that life—and professional life in particular—is too short for most persons to qualify as specialists in two disparate fields. But we do not consider the problem insurmountable. Co-operation is possible in areas where omniscience is not indicated. Neurology and psychiatry are as diverse as psychiatry and public health; their shotgun marriage, as evidenced by the bastard military term "neuropsychiatrist," was forced by the fact that so many psychiatric symptoms ape neurological syndromes—a matter which the psychiatrist might well express in reverse. But the partnership has proved workable and is working. What we aim to express here is the idea that psychiatry—which is a public concern—and public health can, if there be mutual good will, work out a relationship, toward a common end, of a comparable sort.

BOOK REVIEWS

Juvenile Delinquency. By PAUL W. TAPPAN. 541 pages. Cloth. McGraw-Hill. New York. 1949. Price $5.00.

The author, professor of sociology and lecturer in law at New York University, does not specifically state that this is a textbook, but in many respects it is one which will be useful to students of sociology and social work. He does offer theoretical considerations, but fundamentally the book describes the mechanisms involved in the causation, court processing and treatment of juvenile and adolescent delinquents.

Part I attempts to define delinquency. The author advises that, even though an attempt is made to combine social and legal aspects of the situation, "delinquency is any act, course of conduct, or situation which might be brought before a court and adjudicated." In other words, a boy or girl is not a delinquent until so judged by a court.

What causes delinquency is the subject of Part II. The author states, "In an etiological sense, delinquency is perfectly normal behavior. It may be deviant, to be sure, in a statistical comparison of children's conduct, but not, certainly, in the developmental history of the individual delinquent child. On the contrary, it is a natural and inevitable consequence of all the elements that have entered into his growth. Like the nondelinquent, the delinquent is a product of the influences of specific conditioning circumstances upon his reacting organism. And, just as law-abiding individuals are infinitely varied products, so too are law violators; their differences in characteristics of personality and behavior are much greater than the uniformities of their antisocial behavior. Indeed, even in their objectively similar illegalities, they are subjectively distinct, each from every other offender, in the particular configurations from which these similar responses have emerged." More specifically the causes and conditions of delinquency are divided into general, psychological, biological, and social variables.

Part III gives a detailed description of the various types of courts handling delinquent youngsters and the numerous methods of legally defining and disposing of antisocial problems. Such descriptions have occupied a good deal of space in the book because the author believes that they are omitted from most books of this type, and the "court processing" is not generally well known by the average sociologically-interested reader.

Finally, Part IV deals with the treatment of the delinquent. One finds a description of the diverse ideologies employed in dealing with the offender. In theory these seem practical, but circumstances seldom allow their applications. The author states that probation, as generally used, is little more

than a paternalistic method of giving the problem boy or girl another chance. He emphasizes the need for better qualified persons for probation work and for a closer union with psychiatric, medical, welfare and family resources. The author recognizes that in many cases some type of placement is necessary and states:

"It appears that either a good system of foster-home placement for detained children or a good institutional program may fulfill the needs of the child to a considerable degree. There is no ground to assume that one system is intrinsically and universally superior to the other. The ideal would be a combination of the two to insure adequate foster-home placement opportunity for young and somewhat disturbed delinquents and institutional detention in small colonies where a full, active program could be combined with clinical services to provide for the needs of older and aggressive children. It is more important than any arbitrary dogma as to type of facility that the child should not be unnecessarily placed in detention. . . . Among the subjects with which this volume is concerned, probably none is more important, certainly none is more difficult, than the one of delinquency prevention. Difficult, because if preventive goals were to be achieved on a truly large scale, they could come about only as a result of social transformations of a deeper order than our society has ever deliberately undertaken—or even given indication of willingness to contemplate seriously. . . . And however much one may deprecate the personal and social maladjustments that surround him, infinitely more than regret and good will is required to effect any real change in the total picture."

However, the author does believe that at least partial prevention is obtained through the family, the school, the community agencies and some police units. Throughout this book Professor Tappan presents facts to show the reader just how delinquents are handled in society and in court. He gives many pertinent quotations, describes systems used in various states, discusses statutes which apply. As a result, the reader gets a true, yet non-technical, picture of the legal phases of delinquency and of recent treatment methods.

Diagnostics Psychologiques (Psychological Diagnosis). By M. A. SECHEHAYE. 120 pages. Paper. Hans Huber. Berne. 1949. Price 8.90 Swiss francs.

The book contains a description of 12 difficult cases in the practice of a clinical psychologist. We must remember that the work of a "clinical psychologist," as generally understood in European countries, deals not only with the diagnosis of psychiatric conditions, but also with problems of orientation and guidance.

The cases are described in the form of dialogues between an older and more experienced psychologist and a younger one. Every case deals with

the solving of an immediate problem. Generally, the author presents an outline of the case, the results of his examination and of the tests administered, and then presents his solution. Each case deals with a different type of problem. The following examples are typical:

The title of the first is: "Hysterical Paralysis in a Four-Year-Old Child?" It concerns a child—of intelligent and educated parents—who, after some vague physical symptoms, developed a paralysis of both legs and arms. The physicians were in doubt about the organicity of the illness. The psychologist, after a thorough examination, decided that the symptoms did not appear psychogenic. On the basis of this a retrospective diagnosis of poliomyelitis was made and orthopedic therapy instituted.

A second case is entitled: "What to Do with a Disgusting Relative?" The psychologist is called to give her opinion about a 60-year-old unmarried woman who lives with her married brother and who is disturbing his home by being "inefficient, slow, quarrelsome and not proper." The psychologist discovers that she is a moron of the mongoloid type. He advises the brother to make arrangements for the patient to live elsewhere by herself, but under the supervision of the brother and his wife.

Other cases deal with occupational and professional orientation under varied conditions, and with diagnostic and therapeutic indications.

The book is well written, easy to read and interesting.

The Writer's Book. Presented by the Author's Guild. Helen Hull, editor. 355 pages. Harper. New York. 1950. Price $4.00.

Mix naïveté with pompousness, add a few drops of factual information about the few dollars one cannot earn with writing, and you have the formula for this rather silly book. The 40 contributors seem to be in agreement that writers earn around $1,500 a year; that the chances of the beginner are slim; that one out of 450 first novels is accepted by publishers; finally that they are engaged in a difficult profession. So far, banal though correct information is imparted. The moment excursions into the psychology of writing are attempted, the book enters the realm of rationalizations of the not-too-smart variety. If one expert informs us that writing increases the "ground-stuff" of man, and another that the male artist imitates woman's fecundity, one can but laugh and ask whether newer psychiatric-psychoanalytic investigations (e. g., summarized in Bergler's recent book, *The Writer and Psychoanalysis*) are taboo to writers. One could, of course, object that writers' business is to produce out of their unconscious; and so one could disregard their rationalizations. On the other hand, one can also ask whether a publisher, by propagandizing outworn rationalizations, does not perform a disservice, according to Hosea Ballou's dictum, "Not the least misfortune in a prominent falsehood is the fact that tradition is apt to repeat it for truth."

The Paradox of Oscar Wilde. By George Woodcock. 250 pages. Cloth. Macmillan. New York. 1950. Price $3.50.

Here is a learned, hazy, confused, psychologically naïve-pretentious evaluation of Wilde. The author believes that by giving Wilde the epitheton, "schizoid type" (p. 4), the contradictions in his hero's personality are explained. He traces some of Wilde's traits to identifications and counter-identifications with his parents; misses, however, completely the point in not recognizing Wilde's psychic masochism and the reasons for his homosexuality. The author believes that Wilde's maneuvering himself into prison, had relation to his "crazy family pride" (p. 226), overlooking completely the unconscious wish to suffer. There are long passages in the book devoted to Wilde's preoccupation with "sin," "the gospel of suffering," "value of suffering" without an inkling as to what these tendencies really mean.

As to Wilde's homosexuality, the author's dictum reads: "Oscar Wilde's homosexuality is a complicated phenomenon, and it would be *foolish* to explain it by any *one* cause, but his original disinclination towards normal sexual activity may well have been influenced by the distaste a sensitive boy, deeply attached to his mother, might feel for the antics by which his father created unhappiness within his family." Thus a "foolish" new theory on homosexuality is created: Have an "elderly rake" (p. 11) as father, and you are a candidate for homosexuality . . . Not less out of focus is the author's explanation of Wilde's dandyism: The idea that an unconscious caricature of his mother is involved, does not even occur to the author. Of course, this would presuppose some understanding of the inner conflicts of homosexuals, which the author lacks completely.

An ironic touch should be mentioned. The author explains Wilde's subdued behavior in prison with "almost saintly, patience and fortitude." (p. 228). The nearly identical words were used by Samuel Johnson in his famous study explaining Savage's tribulations. This was 200 *years ago!* which all goes to show how little progress has been achieved in literary criticism.

It Won't Be Flowers. By Elizabeth Berridge. 246 pages. Cloth. Simon & Schuster. New York. 1949. Price $2.75.

Here is another example of a book where one wonders what mental processes led to its publication. About the *dramatis personae*, there is little to say: Three dissatisfied girls working in an English bank are ineptly and boringly described. If the author wanted to say anything at all, it must have been a pessimistic message, something to the effect that happiness does not exist for women. But even this idea is transmitted in an amateurish manner.

Bristow Rogers: American Negro. A Psychoanalytical Case History. By ELSE P. HILLPERN, IRVING A. SPAULDING, and EDMUND P. HILLPERN. 184 pages, with appendix. Cloth. Hermitage Press. New York. 1949. Price $3.00.

This is an unusual little book in that it consists largely of the patient's written "free" associations outside the analytic hour, with the analyst's comments on the material and the general movement of the case. Dreams receive special attention, including "A Cross-Reference Synopsis of Dream Analyses" as an appendix. This feature makes it possible to follow the role of dreams in treatment much more clearly and effectively than is usual in case histories. Much is made of the fact that Bristow Rogers, subject of the book, is a so-called "marginal man," and is deserving of special interest on this account. However, it does not appear that his drives, defenses, and psychological mechanisms differ in any important respect from other patients commonly seen in a treatment relationship. It would, indeed, be remarkable if the case were otherwise. Therefore, the authors' suggestions, although quite moderate, that there is extraordinary social significance in this study, do not seem entirely justified.

Les Tests Mentaux en Psychiatrie. Tome I: Instruments et Methodes (Mental Tests in Psychiatry. Volume I: Tools and Methods). By PIERRE PICHOT. XVI and 240 pages. Paper. Presses Universitaires de France. Paris. 1949. Price 500 francs.

The author describes about 140 tests which he feels should be of interest to psychiatrists. Most of these are of Anglo-American derivation, but reference is also made to tests of French, Dutch, German, Swiss and Spanish origin.

The book is divided into two parts. The first dealing with "efficiency tests" (intellectual aspects of personality) and the second with "personality tests" (non-cognitive aspects of personality).

The first part contains three chapters. One deals with "quantitative efficiency tests." In it reference is made to the tests which developed from the early work of Spearman and Binet, including performance tests, the army tests, the Wechsler-Bellevue Scale and other methods designed to measure intelligence. Reference is also made to tests which measure special "mental functions," such as memory and attention; to psychophysiological tests (reaction time, psychogalvanic reflex, visual, auditive, tactile sensibility, etc.); and to the tests which the author calls "perceptive-motor" (including the Goldstein stick-test, the Bender-Gestalt and others). Space is devoted to a discussion of factorial analysis and tests which are based on it (progressive matrices, dominoes test, etc.). The second chapter of the first part deals with the "qualitative efficiency tests," particularly the

ones in which the psychologist investigates the process of concept-formation. Reference is made to the tests of Goldstein, Gelb and Scheerer, Halstead, Rothmann, Vigotski and others. The third chapter is devoted to a discussion of deterioration and the concept of scatter.

The second part of the book deals with personality tests. These are classified into two groups: analytic and syncretic. The author thinks this division corresponds grossly to the American and the German points of view in psychology (chiefly before 1933). In the analytic group he includes tests of character, temperament, attitude, interests and suggestibility, and refers to their validation through empirical, statistical and *a priori* methods. Inventories and questionnaires are also discussed. In the syncretic group, space is given to the projective techniques. After giving some possible classifications of these methods, Dr. Pichot indicates preference for Frank's. Reference is made to the Rorschach, Graphic Rorschach, Group Rorschach, Cloud Pictures of Stern, the tautophone, the drawing techniques, Mira's PMK, play techniques, H. T. P., T. A. T., Szondi, word association tests, fables completion and other projective techniques.

The author's intention was not to present a complete discussion of any of the presented methods. The book cannot be utilized as a text to learn specifically any of the special techniques described. Its utility can be very great, however, because acute and generally wise criticisms are given of the tests, with special consideration of their validity when applied to psychiatric patients and problems.

Letters to My Son. By DAGOBERT D. RUNES. 92 pages. Cloth. Philosophical Library. New York. 1949. Price $2.75.

Dedicated to his mother, "Victim of Teutonic Fury," Dagobert D. Runes has written a brilliant and inspiring volume in the form of letters explaining to youth the contemporary problems and issues of friendship, God, courage, the art of silence, the abnormal among us, of the quest for happiness, of teachers, crime and punishment, and, finally, a conclusion interestingly entitled "Evening Thoughts." *Letters to My Son* is a thoughtful, moralizing, and reflective treatise, in effect, on the meaning of life in its totality. The short essays are penetrating and many-faceted.

The author is the editor of *The Dictionary of Philosophy*, and has contributed widely to literature and the arts. Dr. Runes would have modern youth, as well as adults, plan and prepare for a world that is not removed from morality and ethics. The letters in this little book have in them the quiet eloquence of a person who has thought deeply and seriously. The author is realistic, yet he professes a sensitive feeling for humanity. *Letters to My Son* certainly is a brilliant, succinct, forward, intelligent pronouncement and treatise, written with the quietness born of inner maturity and enhanced with philosophic understanding.

Why Are You Single? By Fritz Kahn, Arthur Garfield Hays, Louis I. Dublin, Marynia F. Farnham, Eduard C. Lindeman, Abraham Stone, Clifford R. Adams, Bernard Glueck, L. Guy Brown, Richard H. Hoffman, Theodor Reik, Beatrice M. Hinkle. Compiled by Hilda Holland. 278 pages. Cloth. Farrar, Straus. New York. 1949. Price $3.00.

Hilda Holland, compiler of these judgments of medical and lay authorities on marriage and its problems, says that this volume was written "to clarify the reasons why men and women remain single" and "to create a more sympathetic awareness of the problems of the single in families with members past the marrying age."

With 29,000,000 people of marriageable age in the U. S. (the figures are the Census Bureau's) it is interesting if not imperative to discuss why we have so many spinsters and bachelors with us. Lack of opportunities to meet the opposite sex is frequently considered—outside the psychiatric literature—to be one major reason. Chapter headings suggest others.

"Facts and Fancies" by Abraham Stone explains that some of "the unmarriageables" may not even be aware of why they do not marry and are possessed of "fears without reason!" "Marriage Neuters" by Marynia F. Farnum deals with marriage as a defense—a compromise without substance. L. Guy Brown discusses "Deserters from the Marriage Process" and Arthur Garfield Hays in "They Tried It Once" shows how the law and its penalties are to blame for many a frustrated attitude on the part of the divorced person who will not try again. The discussion by Theodor Reik is, if course, of particular interest to psychiatrists.

An appendix listing accredited Marriage Counsel Services is one of the most valuable features of the book.

Psychiatry for Nurses. Third edition. By Louis J. Karnosh, B. S., Sc.D., M. D., and Dorothy Mereness, A. B., M. N., R. N. 437 pages. Cloth. Mosby. St. Louis. 1949. Price $4.00.

This is a comprehensive discussion of psychiatry for nurses, at the general, basic level. The authors' declared aim in this textbook is to present to the nurse the story of psychiatry, including the newer developments in the field, in such a manner that the nurse will be more capable of making her own distinct and personal contribution to the program. Emphasis has been placed upon the fact that the nurse must reorganize her thinking so that she senses the importance of not merely giving care, but of becoming a living integral part of the patient's progress toward recovery. As the authors point out, the concept of meting out nursing service in a strict efficient manner with an almost unfeeling dispatch has no place in psychiatry where a nurse is helping a mentally-ill patient to live again in a normal environment.

The various roles the psychiatric nurse will be called upon to assume are pointed out as those of teacher, student, a member of a psychiatric team, a friend of the patient, a mother substitute, etc., in the nurse-patient relationship.

There is a chapter giving a brief discussion of mental deficiency, which is informative for the general nurse, but is far too brief for any nurse planning clinical practice with patients in this area.

On the whole the text accomplishes the aim of the authors but there are certain statements relative to treatment and diagnosis presented as accepted facts which are, or may be considered, controversial issues according to the school of thought represented. For example, on page 187, it is stated: "Schizophrenic excitements are best treated by the continuous tub or cold wet pack." Because the nurse must be prepared to function in the care of the patient, regardless of the school of thought represented by the physician or physicians handling the case, it is advisable that the student does not get a fixed idea that one certain treatment is best, since treatments will in all instances be ordered by the doctors.

Rather it is fundamental that the student learn that co-operation in the program of treatment is essential and is dependent upon knowledge and skill in accepted methods and techniques—any one or all of which may be employed under certain circumstances. In this way the nurse may be prevented from developing anxieties or resisting treatments ordered by the physician. This is a point which could be given more careful consideration in many textbooks prepared for nurses.

At the close of each chapter a number of questions are listed which should aid the student in clarification of her ideas and in selection of the significant in the text.

The bibliography is up to date and includes both nursing and psychiatric textbooks.

The Invisible Glass. By LOREN WAHL. 230 pages. Cloth. Greenberg, Publishers. New York. 1950. Price $2.75.

The story deals with the suicide of a homosexual lieutenant in the United States Army in Italy. As he is attracted to a Negro soldier, the narrative is interspersed with a good deal of discussion on race prejudice.

The well-reported and poorly-written book can be used to demonstrate the profound difference between talented journalism and real creative writing. Many of the interesting scenes of the book convey the impression of stenographic protocols. Creative writing is something else: The real writer's *dramatis personae* possess an underlying unconscious psychology. The latter is unwittingly hinted at by the creative writer, though he himself may consciously be fully unaware of it. Nothing of this kind is visible in Wahl's book.

The Diagnosis and Treatment of Sexual Disorders in the Male and Female Including Sterility and Impotence. Third edition. By MAX HUHNER, M. D. 516 pages with index. Cloth. F. A. Davis. Philadelphia. 1945. Price $4.50.

This reviewer intends no flippancy here in recalling the ancient story of the German, English, French and American zoologists who were asked to contribute to a symposium on the elephant and who produced, respectively: *An Introduction to the Study of the Elephant (VIII Vols.)*, *Hunting the Elephant*, *The Sex Life of the Elephant*, and *Bigger and Better Elephants*. It serves to illustrate, however tritely, that when an eminent urologist, genito-urinary surgeon and gynecologist speaks of sexual disorders, and an equally eminent psychiatrist does the same thing, their viewpoints are as far apart as those of any two of the naturalists in the fable.

Huhner's book treats of sexual disorders from the viewpoint of the genito-urinary and gynecological specialist and surgeon, and is designed to enable the general practitioner to "treat the various conditions presented." The book is a comprehensive and authoritative description of the common physical malfunctionings of the human sexual apparatus and of the medical and surgical measures currently in vogue to treat them. As such, many psychiatrists would find it a very useful volume indeed for diagnostic and treatment purposes in the many physical disorders of the genitalia which may be concurrent with psychiatric disturbances.

The psychiatrist will look in vain, however, for even remotely adequate description of psychiatric concepts or psychiatric methods of treatment; and with some of Huhner's conclusions, most psychiatrists will take violent exception. Huhner makes a valiant effort; of psychoanalysis, for example, he declares, ". . . no one has greater respect for the theory of psychoanalysis than I have. No one appreciates more than I do the great value of psychoanalysis as a therapeutic measure in certain conditions." This is in a discussion of "functional impotence," and, be it noted, he states that he has worked with psychoanalysts and sent patients to them. But he goes on to recite endocrinological reactions to indicate a hormonal basis for such conditions as homosexuality, although "in some cases there is a difference of opinion among the endocrinologists themselves concerning their value." He does not discuss psychotherapy for functional impotence but mentions sinusoidal-faradic stimulation, testosterone propionate, and the Steinach operation (of which he disapproves in young men).

In the treatment of "idiopathic" enuresis—after excluding "any pathological condition as a possible cause"—Huhner finds "nothing has thus far superseded belladonna pushed to its physiological limit and persisted in for a long time." He also notes the instilling of weak solutions of sodium nitrate in the urethra, prostate massage and use of tincture of lyco-

podium, with varying results. He has used electricity "on several occasions and sometimes with success," but believes that "in the latter the influence was purely psychic." This is Huhner's only mention of anything "psychic" in connection with this condition.

"Masturbation," says the author, "is the most widespread of all sexual diseases, not even excepting gonorrhea. . . . Masturbation is a real disease . . . dependent [in the adult male] upon a pathological condition of the prostatic urethra." Huhner treats this condition with weak solutions of silver nitrate in the deep urethra and a dietary regimen—he reports "excellent results." He finds masturbation less serious in the female than in the male, but a disease, nevertheless. In treating the unmarried female masturbator, Huhner seeks "to remove all psychic conditions which stimulate the sexual imagination . . . erotic literature, impure plays, moving pictures, etc." This is the closest approach, noted by this reviewer, which the author makes to psychotherapeutic treatment. In the case of the adult married woman who masturbates, Huhner's treatment apparently is concentrated on re-educating the husband.

Useful as this book can be, the psychiatrist will hesitate—to understate the matter vastly—to recommend it to anybody who is likely to accept the author as an authority on psychosexuality as well as urology, least of all to the general practitioner who has had no special training in psychiatry.

Author's Guide for Preparing Manuscript and Handling Proof. 80 pages including glossary and index. Cloth. Wiley. New York. 1950. Price $2.00.

This manual has been written particularly for the scientific and technical writer. It can be recommended without reservation, but the apprentice writer should be cautioned that practices regarding capitalization, punctuation and other matters of style vary from publisher to publisher. For example, the styles for references and footnotes, as given in the *Author's Guide*, are not those in use in this QUARTERLY. Editing and proofreading, however, are standard procedures. They are technical procedures; and only the person whose work is in the field appreciates the problems which lack of familiarity can create. For example, there is a note in the *Author's Guide* on "minimizing the cost of proof corrections." Most publishers would consider this feature alone to be worth the price of the volume.

The present book is a revision of one called *The Manuscript—A Guide*, which went through three editions following its first publication in 1924. It has been brought up to date and is thoroughly in line with modern printing practice. This reviewer cannot recommend too strongly the use of this guide for the novice writer of scientific articles.

Human Relations in the Classroom. By EDMUND BULLIS. Two volumes, Vol. I, 222 pages; Vol. II, 219 pages. Cloth. Hambleton Co., Inc. Wilmington, Del. 1947. Price $3.00 each.

Any teacher worthy of the name needs only a few hours contact with the average class to realize that if learning is to take place these assorted elements of humanity—diverse in backgrounds, interests and capabilities—must temporarily at least, become fused into a unit that will listen creatively. If such is a condition of learning, what of the student whose mental stresses outlaw him from the listening group? What of the misfits who, statistics tell us, exist among every 100 pupils—four of whom will end up in mental hospitals, another turning to crime, and eight more being shattered by emotional breakdowns?

To strengthen children emotionally and give them some knowledge of the mental problems common to all human beings, is the purpose of *Human Relations in the Classroom*, a course in mental hygiene, by Edmund Bullis, director of the "Delaware Plan," who is working in conjunction with the Delaware Society for Mental Hygiene. The United States Government has made Bullis a special consultant to the Public Health Service and will finance his traveling expenses to any state which is interested in inaugurating its own Delaware Plan.

The general procedure for each lesson in the Bullis plan is to open with a stimulus story or incident about people and their reactions to familiar life situations. Pupil discussions follow, and are guided to bring out significant factors which develop insight into the behavior illustrated. Many times students are asked to write their comments, a procedure which not only permits shy children greater freedom of expression, but allows them to bring up problems which are troubling them personally. This method of presentation can, of course, be adapted to suit the individual teacher's technique and meet varying class needs.

Lessons in Volume I were planned for the eighth grade level but have been used successfully in the sixth, seventh, ninth and tenth grades. This is scarcely strange since our emotional problems are not classified into grade levels. Typical lesson subjects are "Public Enemies of Good Human Relations"; "Making Difficult Decisions"; "How Personality Traits Develop"; "That Inferiority Feeling"; "Establishing Worthwhile Goals"; "Can Personalities Change?" and "Our Need for Faith."

Faces of children photographed during such discussions are more convincing of the value of such a course than verbal comments.

The course, as it stands now, is being given weekly in 71 Delaware schools, and more than 1,000 Delaware Plan classes are in session in other sections of the country with large-scale programs in Massachusetts, North Carolina and Louisiana.

How to give children more experience with life problems has long been the concern of progressively-minded educators. How successful such experience will be is certainly contingent on youth's ability to achieve self-discipline and to demolish gradually the barriers of ignorance and hatred. *Human Relations in the Classroom* can be a powerful weapon toward achieving these goals.

The Negro's Morale, Group Identification and Protest. By ARNOLD M. ROSE. 144 pages. Cloth. University of Minnesota Press. Minneapolis, Minn. 1949. Price $2.50.

This book is of special interest not only to the person studying the sociological problems presented by the Negro but equally of interest to the Negro, himself. Dr. Rose, associate professor of sociology at the University of Minnesota, has studied the Negro problem for many years and is unquestionably qualified to suggest possible solutions.

Group identification is a term which the author uses synonymously with morale. In following the growth of group identification through the years from slavery to the present the author presents many not well-known facts. He shows, for example that Booker T. Washington, although a great man, was not always a champion for the Negro cause. However, the historical facts do show a building-up and a solidification of morale or group identification among the colored folk in this country. Factors which have tended to weaken this solidarity have been factors within the Negro group itself. Shade of color, classes within employment groups, personal and social disorganization, ideological differences and inter-class hatred have interfered with social progress. But in spite of these factors, morale, or group identification has been improved and has been promoted through closer communication among groups, through community institutions, through the churches, through the press and "the protest" organizations, through books and through stimulating a feeling of "Negro self-glorification" and pure race supremacy. These factors have created a unity of aims and greater contentment. In addition, they have created a solidarity with other subordinated groups such as the people of India, of Ethiopia and of the Semitic world.

As to the future of group identification the author states as follows: "We have seen how the growth of group identification has increased the self-confidence of Negroes. It has made them less ashamed of being Negroes and prouder of the fact that they are the group more sinned against than sinning. It has also materially affected their relations with whites. In the first place, it has given them more ease and poise in their personal relationships. . . . Secondly, the growth of Negro group identification has aided the development of effective protest organizations. . . . Thirdly, Negroes as a group have learned to make their vote count. . . . Fourth, a large

proportion of Negroes have become aware of events throughout the country and throughout the world which affect them. . . . Allied to this perspective is a fifth influence of the growing group identification—the fact that Negroes now protest nearly every significant instance of discrimination. They no longer 'take it lying down,' but rather seek to make the offending whites as uncomfortable as possible. . . . The Negroes' aim is full achievement of democracy and its concomitants—liberty, equality, and fraternity—or, in negative terms, the elimination of the terrors and of discrimination and segregation. . . . One of the Negroes' chief supports in this battle is a feeling of strength and pride in their group and its cause."

The Sisters. By ANNE MEREDITH. 282 pages. Cloth. Random House. New York. 1949. Price $2.75.

In this novel two sisters are portrayed, one beautiful, vivacious, attractive and morally not too careful; the other rather ugly, serious and morally scrupulous; they are the daughters of a clergyman. It is evident that the former would be showered with attention and favors both at home and abroad, while the latter would be kept in the background and burdened with the household duties and obligations, which grow greater after the mother's death. Through some unusual circumstances, however, the homely girl acquires a good-looking, well-principled husband who is a lawyer ready to defend the down-trodden. They live happily together, but he ultimately meet his wife's attractive sister and has a clandestine love affair with her. When his wife confirms her suspicions of this, she plots his destruction, rationalizing her actions on the basis of saving him from ruin and disgrace.

The sibling rivalries and the influence of environment in early life on the individual are well brought out.

Psychiatry in a Troubled World. By WILLIAM C. MENNINGER, M. D. 636 pages. Cloth. Macmillan. New York. 1948. Price $6.00.

As chief consultant in neuropsychiatry to the surgeon general of the army during the last war, the author of this book has seen the evolution of psychiatric practice in the army and has fought for its recognition as a specialty against many prejudices, even on the part of colleagues in allied fields.

The author pleads now, like Col. Thomas Salmon after the first war, for the acceptance of these experiences by civilian psychiatry. Vol. X of the *History of the Medical Department in World War I* was devoted to neuropsychiatry. It appeared in 1929, but failed to receive proper attention even in army circles; and in many cases, World War I mistakes were repeated in World War II.

In the first part of the present book, Dr. Menninger discusses the soldier, his personality, the problem of environmental stress and strain and

his emotional support through good leadership, motivation and strong identification with the group. He summarizes the clinical observations made during the war in psychoses, and in psychoneurotic and behavior disorders, and examines in detail the problems of malingering and homosexuality. The importance of excluding men only on the basis of longitudinal life studies of personalities and not on cross-sections at induction centers is emphasized. Even physicians with psychiatric training are not specialists in selection.

All the knowledge gained and tested during the war should be used to help people get along with other people and make them realize that failure in adjustment is not a disgrace, but a reason to seek well-qualified help. If this is done in an early stage, mental illness can be prevented. This is the theme of the second part of the book, which is followed by an appendix consisting of a list of official publications and circulars, the nomenclature developed and used by the army which replaced the "standard nomenclature," the characteristics and attitudes of the soldier during World War II and reference data which include graphs, charts, tabulation of figures, and lists of names of neuropsychiatrists, who served during the war and after VJ Day.

This book has a wealth of material. The detailed index will be of special help to those who wish to use this volume as a source of reference. For all who deal with the individual and the group in our modern society, it will be most instructive and stimulating reading.

Current Therapy 1950. Latest Approved Methods of Treatment for the Practicing Physician. Howard F. Conn, M. D., editor. 704 pages. Cloth. Saunders. Philadelphia. 1950. Price $10.00.

This large book contains information which will keep the physician up to date on methods of therapy, and it should have a place on every medical doctor's desk, for quick and easy reference. It follows the same form and is the same size as that of *Current Therapy* 1949, but it contains 16 new subjects, a new section on diseases of the locomotor system and a section on infectious diseases, which has been revised to include the latest information on chemotherapy.

Rather than review the literature, *Current Therapy* actually records treatment methods used by 250 well-known contributors. One finds specific but varying methods of therapy followed by different physicians. Such new treatments as that with veratrum viride in hypertension, dramamine in motion sickness, vitamin B_{12} in pernicious anemia and aureomycin and chloromycetin in urinary infections are recorded. In other words, if a doctor has made a diagnosis he can easily and quickly decide upon the best procedure for treatment by consulting this book which "puts it on the line" in a few words.

The Liberal Imagination. By LIONEL TRILLING. 303 pages. Cloth. Viking. New York. 1950. Price $3.50.

Lionel Trilling is one of the most intelligent literary critics this country possesses; he is honest, gentle, has wide knowledge (even some knowledge of psychiatry and psychoanalysis); these advantages are counterbalanced by the fact that he is filled with doubts and inner pessimism, although he tries to hide it. The combination of these qualities results—as far as psychiatry is concerned—in a mixture of good will and half-misunderstanding; sometimes (if his prejudices don't interfere), in real grasping of the unfamiliar topic. One could, of course, say that all this is Mr. Trilling's personal problem and worry. Reality proves it otherwise: The critic influences a great many people who accept prefabricated opinions.

In the present volume, Trilling compiles 16 studies published during the last decade. Topics range from writers and writing, to art and psychology, to politics and culture. For the psychiatric reader, three studies are of importance: that on the Kinsey Report (Trilling at its best), and two papers on Freudianism and literature.

"Freud and Literature" appearing first in the *Kenyon Review* in 1940, had profound influence: Trilling became the exponent of a friendly-critical attitude toward psychoanalytic-psychiatry, and, as many believe, "the bulwark against exaggeration." In rereading Trilling's, by now famous, piece on Freud, one finds that he rejects practically everything the founder of psychoanalysis has ever said about art and artists, to credit him only with his "whole conception of the mind," concluding that "What he contributes outweighs his errors."

Strangely enough, Trilling partly misunderstands Freud's conception of the "unconscious repetition compulsion" by understressing active repetition of passively-endured experiences (to restore a lesion in narcissism) —a reparative tendency so powerful that these experiences are repeated independently regardless of whether they were originally pleasurable— and bases a theory on Freud's tentative assumptions as to the nature of traumatic neurosis. Trilling calls it the "mithradatic function" of tragedy, obviously meaning some sort of antidote against psychic "poison," a process "by which tragedy is used as the homeopathic administration of pain to inure ourselves to greater pain which life will force upon us."

In continuation of his studies on Freudianism, in "Art and Neurosis," Trilling again rides his hobbyhorse, and denies the close interconnection between neurosis and creative activity. He wishes 100 per cent normality attested to the writer as writer in his sublimation. He concedes the existence of merely banal conflicts in the artistically creative person—conflicts, not different from those encountered among "scientists, bankers, lawyers, or surgeons." Trilling seems to accept Bergler's assumption that the writer expresses in his work unconsciously not his repressed wishes but only the

defenses against these wishes, but objects at the same time (without seeing the contradiction) to Bergler's clinical proofs of the oral-masochistic regression in these writers. Once more, half-misunderstanding enters the picture: ". . . Dr. Bergler believes that there is a particular neurosis of writers, based on oral masochism . . . But a later development of Dr. Bergler's theory of oral masochism makes it THE basic neurosis, not only of writers but of everyone who is neurotic" (p. 171). This allusion to *The Basic Neurosis* (see review in this journal, 1949, pp. 777-778) is based on "title reading." Bergler holds that in addition to the oral-masochistic substructure an "additional factor," characteristic for each subgroup specifically, is discernible; that additional factor is overlooked by Trilling for the subgroup "writers"; hence his objection loses its impact.

This unwillingness to accept facts, stressing "tangential" acceptance, leads Trilling to the curious dictum that all modern novels must be political: "And since liberal democracy inevitably generates a body of ideas, it must necessarily occur to us to ask why it is that these particular ideas have not infused with force and cogency the literature that embodies them" (pp. 301-302). The answer is obvious: The writer produces to solve his *unconscious* conflict, and not to meet humanitarian aims.

Despite all half-misunderstandings and inner resistances, Trilling's book is highly interesting, in parts even fascinating. It is a book for discerning connoisseurs, willing to accept facts, but also capable of rejecting prejudiced resistances.

Modern Clinical Psychiatry. By ARTHUR P. NOYES, M. D. Third edition. 525 pages. Cloth. Saunders. Philadelphia and London. 1948. Price $6.00.

In the third edition of his book, Dr. Noyes, who is superintendent of the Norristown State Hospital, Norristown, Pa., has emphasized the dynamics of personality development and function. Modern concepts are clearly presented, and today's accepted practice is described.

Most instructive is the chapter on psychoneurotic disorders, in which he reviews the important theory beginning with Charcot, through Bernheim and Janet to Freud, giving ample space to the psychoanalytic concept of personality structure. Psychotherapeutic technics are divided into the genetic-dynamic group of Adolf Meyer and Freud, and the supportive group. Summarizing briefly the development of physical therapies in schizophrenia and affective disorders, he describes the technics of the different forms of treatment which are used nowadays. Excellent is the short chapter on child psychiatry.

This book, which originally grew out of lectures to senior medical students, can be recommended to all those who wish to obtain a clear understanding of modern psychiatry.

Die Elemente der Nervosen Tatigkeit. (The Basic Elements of Nervous Activity). By A. E. KORNMULLER, professor at the Kaiser-Wilhelm Institute for Brain Research, Physiological Division, Gottingen. 120 pages including 6 pages of references and 43 illustrations. Paper. George Thieme Verlag. Stuttgart. 1947. Price 13.50 (Reichsmark).

The author reviews present-day concepts of the anatomy and physiology of nerve action, reviews much of the basic literature and concludes that present theories are insufficient to explain all the facts now known. He admits that physiology has long since abandoned any serious attempt to reconcile its findings with present anatomical concepts. His illustrations of nerve histology are drawn from various classical works.

The author proposes a new theory, namely that all the non-neuronal ectodermal elements in the nervous system take part in nervous activity and in particular that the so-called mantle cells—which he states form a plasmodium around the ganglion cells—have such an activity. These plasmodial cells are themselves innervated by short nerve processes which penetrate deeply into them and end in meshworks of various patterns. They in turn exert a local humoral effect and a general effect through a secretion which passes into the blood stream. The effect may be excitatory or inhibitory. Specific areas such as the sleep areas of the brain may produce specific hormones, and a sleep hormone may actually exist. The Schwann cells have the same function with regard to peripheral nerves as does the plasmodium in the central nervous system. The author further suggests that other non-neural cells of ectodermal origin in the nervous system may play a similar role.

He finds that neurofibrils shows a discontinuity, and is opposed to the idea of a continuum of nerve fibers throughout the nervous system—thus accepting the individual neuron as a basic unit. However, he holds that the synaptic function is not on the cell surface but in the depths of the cell just as in the motor end plate and in the sensory end organs. Entering nerve impulses play across this deep synapse upon the cell nucleus and upon nuclear derivatives in the cytoplasm. The author is of the opinion that the molecular structure of the nervous system will be found to be of the greatest importance.

A series of applications of these theories is suggested. Ablations may be done in living animals; and, after degeneration has occurred, examination of the related ganglion cell groups should be made to determine whether the extra-cellular or intra-cellular fibrillary system has undergone degeneration. If the external fibrillary system is degenerated, the direction of impulse is from the location of the section to the cell. If the internal fibrillary system is degenerated (perinuclear system) then the direction is from the ganglian cell to the point of section. The Nissl picture also is important to observe.

A histological special study of mantle cells (plasmodia) in normal and pathological conditions seems very important, as does an examination of other neurogenic cells (including neuroglia). This is particularly recommended in conditions such as psychoses in which, so far, no clear-cut pathology has been established. Since the author ascribes great importance to the cell nuclei in the functioning of synapses and also for the activity of the motor end plates he points out the significance of the finding in myotonia congenita that there is damage in the motor end plate with increase in the nuclei of the sarcolemma. Viruses resemble nuclear substances, and virus infections attack cell nuclei first and most severely. In reviewing these facts, he comes to the idea that some diseases may be primary in the mantle cells and others in the neuronal elements. He hopes to find indications that the nuclear effects are secondary in some cases and thus to open up new therapeutic possibilities.

In summary, one may characterize this book as a bold but carefully-reasoned attempt to set up an important change in present-day concepts of nerve functions. Even for readers who are unable to accept the main thesis, there is much to be learned from the material presented. Conclusions are based on information already available in the literature.

Perhaps the most challenging detail in the book is the suggestion that the EEG, so difficult to explain by present theories, may be an expression of the influence of the plasmodium, surrounding the ganglion cells and controlling them over a wide area in a synchronous fashion.

Sexual Deviations. By Louis S. London, M. D., and Frank S. Caprio, M. D. Foreword by Nolan D. C. Lewis, M. D. 669 pages. Cloth. Linacre Press. Washington, D. C. 1950. Price $10.00.

This book is apparently a very popular one because it has been promptly and favorably reviewed in recent publications. Perhaps this is due to the fact that a new comprehensive treatise on deviations of sex behavior is timely. Hitherto such vast knowledge has not been integrated in a single volume. In this book Drs. London and Caprio place their greatest emphasis upon psychodynamics which are explained in psychoanalytic terms. But historical, therapeutic, social and legal considerations are also given. Thirty-eight sex deviations are defined and described. The concepts presented are illustrated by many detailed case histories of patients who have been treated by the authors in psychoanalytic sessions. Of particular interest is a case of female homosexuality where Dr. London collected over 960 dreams which he presented to Dr. Caprio who knew nothing of the case, not even the sex of the patient, yet was able to so analyze it that his description of the patient's physical characteristics, history, symptoms and etiological factors corresponded closely to the facts.

The authors note that sexual deviations are widespread in our society. They hold that, actually, there is wide variation in what differentiates the normal from the abnormal; that perversions are substitutes instead of variations of sex expression; that sexual deviations are expressions of underlying neuroses of an obsessional type which originate in childhood; that no one is born with sexual deviations; and that most patients with such deviations are amenable to psychoanalytic therapy. The authors call attention to the fact that many psychosomatic symptoms such as insomnia, eye disturbances, enuresis, gastro-intestinal disturbances, dysmenorrhea, fatigue and cardiac symptoms may be caused by psychosexual conflicts which are easily alleviated by psychotherapy. As to medico-legal aspects, they state that "the institutionalization and treatment of sex offenders offers the most intelligent approach toward the prevention of tragedies, accounts of which fill our daily newspapers. . . . As a primary factor in the organic and psychic field of human life and experience, sex is therefore the focus of an immense and intricate cluster of social institutions, attitudes, taboos, laws and problems."

This book has other assets, including large type. It is interesting and easy reading, not excessively technical, has a glossary, a large bibliography and index. It will be a useful reference tool for those studying and treating abnormal behavior.

Autosuggestieve Psychotherapie. By Berthold Stokvis. 137 pages. De Tijdstroom-Lochem. 1950. Price 8.95 fl.

The author, a Dutch psychiatrist and member of the staff of the Psychiatric Clinic of the University of Leyden, is particularly known in his own country for his book about hypnosis which appeared more than 10 years ago in Holland. In the present volume, also written in Dutch, he gives a critical evaluation of autosuggestion as a psychotherapeutic method and a practical guide for students and physicians, who have neglected this method so far—undeservedly, feels the author, because it has been known and practised for more than 3,000 years in India.

He discusses extensively Yoga philosophy from its founder Patanjali down to the thirteenth century, and the evolution of the Yoga technique to the Hathayoga. He prefers to use Sanskrit terminology in transcription and seems to have studied this subject thoroughly, describing the different exercises of the Yoga-system, which he considers the basis of all the methods propagated in the West. Analyzing the psychic mechanisms of suggestion and autosuggestion he points to their relationship and stresses the essential differences between them. Practically every psychic and somatic process can be influenced by autosuggestion, says the author. His critical review of the different autosuggestive methods and procedures used is con-

cluded with a summary of the indications, contraindications and dangers in certain instances.

Dr. Stokvis has treated 75 cases, in which this method was employed, from 1932 to 1941. He gives the case histories of 20 and the method used at the clinic in Leyden, which consists basically of active regulation of muscle tonus. He appeals to the responsibility of the patient to participate actively in his recovery and explains to him the power of self-cure. Interesting, are the author's remarks regarding the personality structures of physician and patient. He feels that treatment will be more successful when both are anal erotics with marked compulsive-obsessive traits. If the physician has but little interest in his patient and desires to give little of his time, then he will show special preference for autosuggestive therapy (p. 77).

This reviewer feels that Dr. Stokvis' attempt to convince the medical profession of the importance of the autosuggestive method is not successful. Statistical data comprising only 75 patients treated with Dr. Stokvis' method, compared with results in 30 patients treated by Carp, who is a follower of Alfred Adler, are in every respect inacceptable. This book, however, may become popular and widely read in lay circles, which may use this guide, trying one method after the other, starting with Coué. The danger of the exercise called "discovery of the heart" is noted, even by the author.

Nobody, however, will deny that suggestive and autosuggestive mechanisms play an important role in every medical treatment.

The Road Between. By JAMES T. FARRELL. 463 pages. Cloth. The Vanguard Press, Inc. New York. 1949. Price $3.50.

In this novel Farrell presents, with the realism for which he is noted, the old story of the father addicted to drink, reacting with abusive and violent behavior toward a sober, steadfast and religious wife. The story centers mainly around one of the sons, Bernard Carr, a sensitive individual, in revolt against his father and, hence, against any authority which represents father. This leads him, for a time, to lean toward radical groups, undoubtedly on an emotional basis. In his confusion, he still looks for security by marrying and clinging to a wife who is the only child of a well-established and financially-comfortable undertaker, and who will inherit her father's money. It is also significant that Bernard the idealist, is afraid of physical pain—as demonstrated at the wake for his father when he is threatened with violence by one of his boyhood friends who resents references Bernard made to him in a book about his early background.

The book gives us a very good description of how a disturbed home in childhood can influence adult behavior.

Society and Its Criminals. By PAUL REIWALD. Translated and edited by T. E. James. 308 pages. Cloth. International Universities Press. New York. 1950. Price $4.50.

The author, criminal lawyer and reader in criminology at the University of Geneva, has written, not just another book on criminology but a different book on criminology. His attack is not against the individual criminal but against society. He declares that his concepts of the criminal and of society have been altered through his study of psychoanalysis. Specifically, he holds that the asocial person cannot be isolated from the society which inflicts punishment, and notes that he cannot believe that asocial outbursts are directed against the law and nothing else. He maintains that society does not punish the criminal mainly to protect society or because that person has committed a sin for which he needs to be punished; but that society punishes "in order to abreact its own unconsciousness." He states, "It is only by changing the attitude of the society which inflicts the punishment that a real alteration in criminality can be expected . . . The infliction of punishment which is free from unconscious aggression will no longer be an infliction of punishment. . . . Society must learn the secret of all education: to give treatment instead of reacting emotionally."

The author does not specifically blame the courts or persons associated with the courts but does blame antiquated criminal law. However, he does believe that many judges and lawyers do not allow themselves to become fully acquainted with the asocial person; that they sentence persons to places they have not visited and usually do not want to visit; that the court fails to employ information which could be made available through social agencies, social workers, psychologists and psychiatrists. "Humanity and practical psychology, the understanding of the essence of human affairs, these are the qualities which people look for in the ideal judge, not the immense knowledge of statutes and their sections, and their perspicacious exposition."

The author states that criminal law is now thought to have been established mainly to protect society but that it actually has anthropological reasons based upon the psychological factors relating to punishment. He says that society has always condoned "the contrary ones" because it has a need for the criminal. "In the fight against crime man has not been able to rid himself of the criminal. It seems that, in fact, he has grown to manhood in waging this fight. The criminal is necessary to him; he cannot be dispensed with. We must ask the question whether perhaps an important social function should not be ascribed to the asocial, similar to that of the devil, who always desires evil and always creates good? . . . But these criminals . . . are only possible under our current moral and social conceptions. They are a part of us. They can only change, and they would do so, if we ourselves altered."

The author devotes a chapter to "The Genesis of Punishment" and attempts to show that ". . . the criminal represents the totem animal, and that the execution is a renewal of the totem feast . . . The forces, to which the execution as a sacrificial feast has given effect, are found behind what has replaced them to-day. Permitted, indeed ordered, aggression and therefore aggression as a festivity and as a feast, even to-day are amongst the deepest traits of criminal justice."

". . . And it is precisely a change of heart that is required to transform criminal law. The time is past when men believed that it was possible to dispense justice by means of judgment and punishments. Our better understanding is for this reason important, that is, the understanding that man is neurotically fixated on crime and the criminal, that he places the whole force of his projection on the asocial, that in the same breath he fights and preserves the criminal, and that aggression even to-day forms the kernel of criminal law. . . . In effect there is to-day an unequivocal answer to the question, what can be substituted for aggression in the criminal: non-violence and self government as a means of education . . . Those who honestly and seriously wish to effect a change in the relationship between the law-abiding citizen and the asocial person will begin where it has been shown to be possible, and where something is capable of being achieved, where in fact the greatest success is promised, that is, with the young persons."

Special Friendships. By Roger Peyrefitte. Translated from the French by F. Giovanelli. 392 pages. Cloth. Vanguard. New York. 1950. Price $3.50.

In the long series of books, dealing with (and partly exploiting) the problem of homosexuality, the present volume is the most boring and unreadable. Although a famous French writer characterized the book as "a masterpiece," the story of two boys in a French Catholic boarding school, is presented ineptly and without psychological insight. A comparison with some parts of *The Thibaults* by Roger Martin du Gard, dealing with a similar problem, shows the whole difference between real artistic presentation and—hopeless boredom.

Limbo Tower. By William Lindsay Gresham. 275 pages. Cloth. Rinehart. New York. 1949. Price $3.00.

The second novel is always a dangerous hurdle for the writer, especially when the first is successful. This dilemma applies to the author of the macabre *Nightmare Alley*. Someone misadvised Gresham to try "optimism" for a change; he fails in this task. The setting of the novel (among the hopelessly sick in a hospital ward) has possibilities. A few interesting scenes result; the whole novel just does not come off.

Meaning and Content of Sexual Perversions. A Daseinsanalytic Approach to the Psychopathology of the Phenomenon of Love. By M. Boss, M. D. Translated by Liese Lewis Abell, Ph.D. 148 pages. Cloth. Grune & Stratton. New York. 1949. Price $4.00.

In the foreword of the book Oskar Diethelm writes, "The author, Dr. Boss, a well-known Swiss psychiatrist and a leader in the Swiss psychoanalytic group, found in the *Daseinsanalyse* of Martin Heidegger certain philosophically-adequate concepts for some of the limitations of psychoanalytic theories. His development led to substitution of a mechanistic and causal-genetic theory by a broad concept of personality with equal attention to subjective experiencing and manifestations which can be demonstrated objectively. As his study of sexual perversion demonstrates, the emphasis on gaining a minute understanding of the subject's individual experiencing led to a broadening of the clinical picture of perversions, a widening of the theoretical concepts, and modification of psychoanalytic procedure. *Daseinsanalyse* is based on the assumption that one must try to understand a person's being; i. e., "experiencing in the here and now as well as in the past." Dr. Diethelm calls *Daseinsanalyse* "a psychoanalytic-phenomenologic psychopathology."

Dr. Boss energetically criticizes the psychoanalytic theories of Freud and the so-called anthropologic theory of perversions of von Gebsattel, Straus, Kunz and Schwartz and leads the reader to believe that the daseinsanalytic conceptions give correct interpretations of perversions. He gives several case histories and, finally, his conclusions.

Your reviewer believes that there will be others like himself who will wonder just what these daseinsanalytic conceptions really are. The author states in his preface that "The German *Dasiensanalyse* translates readily to Existential Analysis . . ." However, after reading the book, your reviewer found himself in a confused daseinsanalytic state.

Studie zur Psychopathologie krampfbehandelter Psychosen. (Psychopathological investigation of psychoses treated with convulsions). By H. J. Weitbrecht. 86 pages. Paper. G. Thieme. Stuttgart. 1949.

The author is one of three editors of the German neuropsychiatric monographs (*Sammlung psychiatrischer und neurologischer Einzeldarstellungen*). In this slender volume he presents a lucid and comprehensive survey of the psychopathology of psychotics treated with artificially-induced seizures. There is much more on electric shock and schizophrenics than on metrazol treatment and manic-depressives. The author is concerned chiefly with the effect of these shock treatments on schizophrenic symptoms, particularly upon the inner psychological status of the schizophrenics.

The two most general conclusions are that the shock treatments do in-

fluence favorably the primary and presumably non-psychogenic (somatic) psychotic symptoms, but that they cannot bring about complete and permanent cure of schizophrenia. The author recommends these treatments, pointing out the great and welcome change which their introduction brought about, not only in ambulatory but in hospitalized psychotics.

Thirty-five succinct case studies are used to illustrate the many points made by the author. Full insight into the symptoms and the personality changes which have taken place as a result of successful treatment should, according to the author, not be considered a condition of marked improvement or recovery, because such an insight is not possible. Psychological processes contingent upon shock treatment, such as amnesia, rapid change of symptoms, etc., are emphasized and well discussed. Weitbrecht indicates when psychotherapy should be used in conjunction with the convulsive treatments, and what the purpose of the psychotherapy should be. The technical aspects of treatment, and statistics concerning incidence and degree of improvement, are omitted.

With the exception of Dr. Delay and his collaborators in Paris, Weitbrecht quotes only German authors. It is therefore interesting to note that his results agree with those reported in this country as far as they are comparable. The physician interested in the practical aspects and results of electric shock and metrazol treatments would find little new in this monograph. However, the psychiatrist interested in the theory of schizophrenia and of shock treatment will benefit. The author has thought through many a psychopathological problem and offers clear, and at times original, formulations. E. Bleuler, K. Jaspers, W. Mayer-Gross and K. Schneider seem to have influenced the author's thinking more than other writers.

Strindberg—An Introduction to His Life and Work. By Brita Mortensen and Brian Downs. 226 pages. Cloth. Cambridge University Press. New York. 1950. Price $2.00.

An informative and unpretentious short biography of Strindberg, written in commemoration of his 100th birthday. The main value of the book lies for the reader in the time-saving summary of Strindberg's plays and novels. In contradistinction to other scholarly biographies, not even an attempt is made to unravel the poet's paranoiac schizophrenia; in the age of psychiatric pseudo-knowledge this is a commendable asset. Where the problem is tangentially approached, it is measured on—reality. Thus, the authors quote Strindberg's accusations that he was contaminated by his wet-nurse ("he had received from her inflammation in his blood, and cramp in his nerves," charges Strindberg in *The Son of a Bondswoman*), and add "with I know not what justification."

The Psychoanalyst and the Artist. By DANIEL E. SCHNEIDER. 303 pages. Cloth. Farrar, Straus. New York. 1950. Price $4.00.

Freud maintained that psychoanalysis has nothing to contribute to the aesthetics of art, hence the problem of form. His skepticism included even the artist's metapsychology (hence results visible in the contents of a work of art). Only in one of his last writings did he concede that research may clarify that point. In the present volume, Schneider attempts the impossible: an investigation of artistic form, although he first claims that he explores the nature of "true talent." The result of his investigation is more than disappointing; what it amounts to is circumlocution. That circumlocution is presented in a rather fancy language, ending many sentences with mysteriously-intended three dots.

More important is the consistency with which all controversial issues are avoided (hence also all contributions to these issues); when they are touched upon at all, they are arbitrarily dismissed without even attempting an answer. Rather peculiar is the tendency to act the final arbiter. With the exception of Freud, no analysts are quoted; even in an appendix (called "suggested references"), mention of the works of such authors as Brill, Sachs, Bergler, is omitted. Not less peculiar is Schneider's attempt to be more papal than the pope in Freudianism, although his own Freudian affiliations are unclarified. Schneider is so shy of quoting that not even an author whose ideas concerning negation of the close proximity of art and neurosis are nearest to his own, Karen Horney, is mentioned.

Finally, a problem of scientific principle should be stated: Clinical investigations have to contain clinical material. No clinical examples are included in the book.

I Attacked Pearl Harbor. By KAZUO SAKAMAKI. 133 pages. Cloth. Association Press. New York. 1949. Price $2.00.

This is the translation of an account, originally written in Japanese for Japanese and published in Japan, of what happened to America's prisoner-of-war number one. He was Ensign Kazuo Sakamaki of the Japanese navy and was captured when his midget submarine was wrecked on the day of Pearl Harbor. His book is valuable as a naïve picture of the psychology of the twentieth century Japanese warrior and its development under the impact of prison life in America. Ensign Sakamaki appears to have come out of the war with at least a rudimentary understanding of what America is about and what appears to be—since this book was written for the Japanese themselves—considerable genuine admiration for America. His document is probably significant and important in pointing to present developments in the once great Empire of the Rising Sun, and the psychology back of those developments.

Makers of the Modern Mind. By THOMAS P. NEILL, Ph.D. 391 pages. Cloth. Bruce Publishing Company. Milwaukee, Wis. 1949. Price $3.75.

The author has chosen 11 men who, in his opinion, have had the most critical influence in shaping the modern mind. His study begins in the latter part of the fifteenth century with Martin Luther. Then follow Calvin, Descartes, Locke, Newton, Rousseau, Kant, Bentham, Darwin, Marx, and Freud. The contemporary history, personality and doctrine of each man are discussed. The author holds that, although there are many other profound and more original thinkers who made their individual contributions to the history of ideas, the thought of these 11 men added together comes close to giving an accurate and complete picture of what is here called the modern mind; they represent milestones in the Western World's intellectual history of these past four centuries. The 11 makers of the modern mind were almost always influential because they said what the world wanted to hear at the time they spoke.

The book makes the claim that the author can be relied upon to remain undeviatingly fair in his treatment of each of these men. However, he often takes a critical and depreciating attitude. He states for example, that both Luther and Freud are reason's greatest enemies; that both deny the supremacy of the intellect and both deny man free will.

Concerning Freud, the reviewer cannot escape the conviction that the author is struggling with inner conflicts of his own so that he finds it necessary to attack vehemently and discredit the man who has disturbed his psychic equilibrium. "Reading Freud," he writes, "is enough to make one neurotic"; and, in his opening sentences, of the chapter on Freud, he complains that although Marx pushed everyone into the vicious struggle for the means of survival, at least he let man retire home to drink his beer and sleep in peace. Freud on the other hand "denies man even peaceful sleep." The author accuses Freud of forcing patients to admit unconscious drives; of forcing facts to fit theories, and of developing his theories on insufficient clinical material. He also misquotes him. He appears to have great difficulties in giving Freud any credit whatever but finally admits that he made real contributions to the medical treatment of the neuroses.

The author criticizes the makers of the modern mind because in his opinion, they attempted to explain the whole of reality by a simple solution. For example, Descartes considered man pure mind and made the mistake of applying the mathematical deductive method to solve all life's problems. He states this desire for a simple solution was also the mistake of Rousseau, who considered man nothing but unadulturated animal-feeling; of Darwin, who explained all things by struggle and survival; of Kant who thought the method of the physicist would give him certainty in philoso-

phy—and so went astray; of Freud, who resolved everything into unconscious drives.

The author holds of the makers of the modern mind: ". . . either they have denied the animal in man in order to rescue the rational element or they deny 'reason' to concentrate on the animal." He says, "it is necessary to recover the Classical-Christian view of man as a rational element," holding that it is man's reason which distinguishes him from other animals, which makes him an intelligent creature who can direct his activities according to the light of reason, and who is, therefore, responsible for his human activities. He says, however, that there can be no return to the thinking which existed before Luther, Darwin or Freud.

He suggests that the ideas contributed by the makers of the modern mind must be acknowledged and, where proved valid, incorporated into any rational system of thought.

The book is not written primarily for the specialist scholar, but for the large number of intelligent men and women desirous of correct information on the important matters dealt with here. It is well written, well organized and has a good index.

Families Under Stress. Adjustment to the Crises of War Separation and Reunion. By Reuben Hill, Ph.D. 361 pages. Cloth. Harper. New York. 1949. Price $4.50.

Dr. Hill, who is professor of sociology and research at the University of North Carolina, and his close associates have recorded in this book an unusual piece of research. It is a study of the adjustment of many Iowa families in which the father was called into military service. The study was conducted by trained interviewers who obtained personal and intimate information. It is not simply a study of the effects of war upon the family but represents a search for characteristics revealed in successful and unsuccessful interpersonal relationships during a family crisis caused by war. Of necessity, several chapters are devoted to statistics, diagrammatic charts and summaries which cannot be reviewed adequately.

The study brought out the fact that the induction of the husband and the father into the service had a very different meaning to different families and that the event itself was by no means a crippling crisis for all of them; that in the last analysis the family's definition of the event was seen as the factor determining whether the separation was a crisis. Very few families considered the reunion a crisis, but rather a joyful event. However, problems revealed by these studies show the wife becoming more independent and thereby creating a role-conflict when the husband returns; and the children growing so close to the mother that they resent the father's return and refuse to accept him as a disciplinarian. (Men rarely admitted it was difficult to settle down to family ties but it was obvious by

their restlessness and moodiness at home and their impatience with the children.) The study shows that factors making for adjustment in separation are also important in determining adequacy of union-adjustment.

The author emphasizes the belief that the importance of the family unit has been neglected too long; that national solidarity depends upon that unit; "that money invested to keep families well is certain to be less than the cost of patching up broken homes. . . . The father does manifestly serve more than a meal-ticket function and that is the only one of many services to the family that the military services were able to replace. To be effective as a family two parents are needed during the child-rearing years."

Finally, the book contains three appendices: a bibliography, methods applied, and questionaires used in the investigation.

Doctor of Medicine. By Irma Gross Drooz, M. D. 308 pages. Cloth. Dodd, Mead and Company. New York. 1949. Price $3.00.

The author describes her experiences as a medical student, as an intern, and during her hospital training in neurology and psychiatry.

In spite of her financial difficulties and other obstacles Dr. Drooz was graduated from New York University, College of Medicine. Subsequently she served as an intern at Beth Israel Hospital, and obtained resident training at Mt. Sinai Hospital and at the New York State Psychiatric Institute. Before entering private practice, there was romance and marriage.

An excellent feature of the book is that the author gives a brief description of the subjects studied in medical school, a matter which should prove particularly helpful to the lay reader. She gives intimate glimpses of her ward work, often of a very human nature; and the lay reader may learn, perhaps for the first time, the long and arduous work of a medical student. The physician will relive his medical student days.

The narrative is very easily read, and Dr. Drooz has a sense of humor.

Weep for My Brother. By Clifford Dowdey. 308 pages. Cloth. Doubleday. 1950. Price $3.00.

This is a curious book: the author sets out to describe the tragedy of "those damned called 'borderlines' and their tragically erosive effect on those whose lives they touch." He attacks psychiatry, and ends up with a good psychological characterization of a psychic masochist. The latter, the schizoid brother's keeper, is the real hero of the book; consciously, the author does not know it. If one can leave out of consideration the author's conscious intentions, disregard his rather silly attacks on psychiatry, a good and readable part remains in the novel.

Your Career in Motion Pictures . . . Television . . . Radio. Charles Reed Jones, editor. 255 pages. Cloth. Sheridan House. New York. 1949. Price $2.98.

If success formulas could be packaged, this one would be worth investigating. Instead of offering the usual warmed-over sales promotion ideas, *Your Career in Motion Pictures* presents a series of vignettes of the personal careers of top-flight stars in three theatrical media. The individual chapters are chats by Alan Ladd, Gene Autry, Loretta Young, Bob Hope and other nebulae of Hollywood, telling, as each sees it, the elements that made success possible.

Radio star Gertrude Berg of "The Goldbergs" talks on breaking into radio; producer Ford Bond does the same with television. Other sections of the book offer guidance in associated careers such as the costume director, the musical director and motion picture public relations, suggesting logical avenues of preparation for the job, be it acting, writing or one of the production fields.

Adults as well as stage-struck young hopefuls are likely to enjoy this new rendition of the success theme song. It has so many variations. From the psychological point of view, however, the book has a serious drawback in failure to discuss adequately the psychology (or "temperament," in show business terms) required for a career in the entertainment field. What the writer of an autobiographical note too often fails to see, may be the most important element in his success; an authoritative discussion in simple terms of the psychological dynamics of the performer would have added materially to the value of this advice-to-youth volume.

Intergroup Relations Centers. By Everett R. Clinchy. x and 64 pages. Cloth. Farrar, Straus. New York. 1949. Price $1.50.

Intergroup Relations Centers is another worthwhile and informative publication by Dr. Everett R. Clinchy, in which he analyzes clearly and summarily the community center as a clinic, intergroup relations in industry, research needs in intergroup relations, and the processes of education in terms of centers. The author would establish intergroup relations centers at universities throughout America to attack prejudice in its insidious forms.

Dr. Clinchy is optimistic about the feasibility of his plan to help men in getting on better with other men, other races, other religious groups. He feels that we have reached the stage in history where Man can study fruitfully and control effectively the causes of prejudice and discrimination as he now studies and controls physical disease.

CONTRIBUTORS TO THIS ISSUE

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Dr. Cameron became physician in charge of the reception unit of the Provincial Hospital, Brandon, Manitoba, in 1929, and, while there, organized mental health work and clinic facilities in the western part of that province. In 1936, he became senior research psychiatrist of Worcester (Mass.) State Hospital and in the same year received the degree of M. D., with distinction, from Glasgow. After serving as resident director of research at Worcester in 1937 and 1938, he became professor of neurology and psychiatry at Albany Medical College and psychiatrist-in-chief of Albany Hospital, Albany, N. Y., in the latter year—remaining there until going to Montreal in 1943.

Dr. Cameron is a diplomate in psychiatry of the American Board of Psychiatry and Neurology and is a fellow or member of more than 20 professional boards and societies. He was elected to the Council of the American Psychiatric Association in 1947. He is the author of three books and more than 70 scientific articles. Dr. Cameron is married and has three children.

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NEWTON BIGELOW, M. D. Dr. Bigelow is acting commissioner of Mental Hygiene of the State of New York, director of Marcy (N. Y.) State Hospital and editor of THE PSYCHIATRIC QUARTERLY. He is inactive as head of Marcy and as editor at present.

Born in London, Ontario, in 1904, Dr. Bigelow was graduated from the medical school of the University of Western Ontario in 1926. Following a general internship, he entered the New York State hospital service at Utica State Hospital in 1929 and has remained with the state hospital system ever since. He was first assistant physician at Pilgrim State Hospital in 1943 when he was promoted to the grade of director and assigned to service, first as assistant, then as deputy, commissioner of the New York State Department of Mental Hygiene. He became senior director of Marcy State Hospital in 1945 and was named acting commissioner of Mental Hyfiiene on April 3 of this year to succeed Commissioner Frederick MacCurdy, M. D.

Dr. Bigelow, senior member of this QUARTERLY's editorial board following the death of the late Dr. Richard H. Hutchings on October 28, 1947, was named editor at that time. He is a diplomate in both neurology and psychiatry of the American Board of Psychiatry and Neurology. He is author or co-author of a number of scientific papers relating to personality in functional and alcoholic disorders, psychosomatic pathology, family care, shock therapy and administration. He is a member of the American Psychiatric Association and other professional societies. His home is in Marcy, N. Y. Dr. Bigelow is married and has three children.

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EDWARD L. MARGETTS, M. D., C. M. Dr. Margetts is registrar and assistant to the director of the Allan Memorial Institute of Psychiatry, Montreal, is a demonstrator in psychiatry at McGill University and is clinical assistant at Royal Victoria Hospital. A graduate in medicine of McGill in 1944, he has had psychiatric training and experience at the Royal Victoria Hospital, the Verdun Protestant Hospital, and the Allan Memorial Institute in Montreal, and at the Provincial Mental Hospital, Essondale, and Shaughnessy Hospital, Vancouver. He served for a year as a psychiatrist in the Royal Canadian Army Medical Corps, most of that period in Vancouver Medical Hospital. He lists his interests as teaching, clinical research and the history of psychiatry, and is teacher of that last subject in the postgraduate diploma course in psychiatry at McGill.

HARRY GERSHMAN, M. D. Dr. Gershman, now a psychoanalyst in private practice in New York City, was in the New York State Hospital service from 1941 to 1949. A graduate of the New York University College of Medicine in 1938, he entered state service at Central Islip (N. Y.) State Hospital and resigned eight years later from the position of supervising psychiatrist in charge of shock therapy to enter private practice. He is a diplomate of the American Board of Psychiatry and Neurology and is a fellow of the American Psychiatric Association. He trained at the American Institute of Psychoanalysis and is now an assistant lecturer there. Dr. Gershman is married and has two daughters.

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HERBERT B. WENDER, M. D. Dr. Wender, born in Brooklyn in 1914, was graduated from Columbia University in 1934, undertook a series of postgraduate studies, and received his degree in medicine at Glasgow, Scotland, in 1941. He was in general practice in England for a short time and then returned to the United States for an internship and residency at Israel Zion Hospital, Brooklyn. After service overseas with the United States Army, he entered New York State service at Brooklyn State Hospital in 1946. He is now a senior psychiatrist at that institution. Dr. Wender has been engaged in group therapy for three years and has been in charge of the group therapy program at Brooklyn, under supervision of the clinical director, for the past year. He is a member of the American Psychiatric Association and the American Group Therapy Association.

SAL A. PRINS, M. D. Sal A. Prins was born in Amsterdam, Holland, in 1902 and received his medical and psychiatric education at the University of Amsterdam—where he supported himself by playing the violin in orchestras. Following graduation, he went into general practice. He studied psychiatry under K. H. Bouman and L. Vanderhorst and took his psychoanalysis under the late Karl Landauer. Dr. Prins served in the Netherlands army in 1939 and 1940. Following the capitulation of the Netherlands military forces to the Germans in 1940, Dr. Prins remained in practice for a short time, then escaped to England in 1941 where he served in the Free Netherlands forces. He continued to study psychoanalysis in England and published a paper based on his own experiences, "Psychological Views on the Escape from One's Country" in the *British Medical Psychological Journal*. Dr. Prins came to the United States in 1947 and since August of that year has been on the staff of State Hospital South in Blackfoot, Idaho.

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JAMES A. JOHNSON, M. D. James A. Johnson was born in 1921. He received his M. D. from the State University of Iowa in 1945 and after an internship at St. Vincent's Hospital, Portland, Ore., served in the United States Army Medical Corps from 1946 to 1948. He has been a resident physician at the Western Psychiatric Institute and Clinic, Pittsburgh, Pa., since 1948. He is a teaching fellow in psychiatry at the School of Medicine at the University of Pittsburgh.

PHILIP P. STECKLER, M. D. Dr. Steckler was born in New York City in 1910, was graduated from the College of the City of New York in 1930, and received his medical degree from the University of Lausanne, Switzerland, in 1935. Dr. Steckler interned for two years at Governeur Hospital, New York City, was in private practice for a time, and went with the Veterans Administration as a neuropsychiatrist in 1942. He served in the army from 1943 to 1946 and was discharged with the rank of major. He was chief of the neuropsychiatric service at the Wichita Veterans Administration Hospital when he joined the staff of the Syracuse (N. Y.) Psychopathic Hospital in September 1946. He is now acting supervising psychiatrist there. He is a diplomate in psychiatry of the American Board of Psychiatry and Neurology and is a member of the American Psychiatric Association. Dr. Steckler is married and has two children. His hobby is gardening.

LEBERT HARRIS, M. D. Born in London, Ontario, in 1924, Dr. Harris is a graduate of the University of Western Ontario, with his M. D. degree in 1947. He interned at the Syracuse University Medical Center and served as resident and senior psychiatrist at Syracuse (N. Y.) Psychopathic Hospital. He is now a resident at Hillside Hospital, Bellerose, N. Y., and a first-year student at the New York Psychoanalytic Institute. He is the author or co-author of several scientific papers, including one on prenatal symptoms in postpartum psychotic reactions, published in this QUARTERLY in October 1949.

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LOUIS LINN, M. D. Dr. Linn is a graduate of the University of Pennsylvania and of Rush Medical College of the University of Chicago, from which he received his degree in medicine in 1938. After a general internship, he served as a resident psychiatrist at New Jersey State Hospital, Trenton; as psychiatric intern at the New York State Psychiatric Institute; and as resident in neurology at Montefiore Hospital, New York City. He served as neurologist and psychiatrist in the army from 1942 to 1945. He is now in practice in New York City, is adjunct in the department of psychiatry, Mount Sinai Hospital, and is volunteer research assistant in the department of neurology of that hospital. He is a diplomate in both psychiatry and neurology of the American Board of Psychiatry and Neurology. He is now training at the New York Psychoanalytic Institute.

Dr. Linn is author or co-author of more than 20 scientific papers, including contributions to this journal, *Diseases of the Nervous System*, the *Archives of Neurology and Psychiatry*, the *Rorschach Research Exchange*, and the *Journal of Nervous and Mental Disease*.

PHILLIP POLATIN, M. D. Dr. Polatin is a graduate of the College of Physicians and Surgeons, Columbia University. He took his psychiatric training at the New York State Psychiatric Institute. From there, he went to Pilgrim State Hospital for nearly four years, then was appointed to the permanent staff of the Psychiatric Institute, where he is now chief of the female service. He is also a member of the faculty of the College of Physicians and Surgeons and is a qualified psychoanalyst. He has done extensive research work in shock therapy and has had numerous scientific contributions published in medical and psychiatric journals. With Dr. H. Spotnitz, he devised a special modification of insulin shock treatment, called ambulatory insulin therapy.

His main interests are teaching and research. As co-author with his wife, the novelist, Ellen C. Philtine, he had a book published in 1949. *How Psychiatry Helps*.

NEWS AND COMMENT

BIGELOW IS ACTING MENTAL HYGIENE COMMISSIONER; WHITEHEAD TO SERVE AS ACTING QUARTERLY EDITOR

Newton Bigelow, M. D., editor of this QUARTERLY and director of Marcy (N. Y.) State Hospital, was named acting commissioner of the New York State Department of Mental Hygiene, by Governor Thomas E. Dewey, on April 3, 1950. He has appointed Duncan Whitehead, M. D., senior associate editor of the QUARTERLY and assistant director (clinical) of Brooklyn (N. Y.) State Hospital, as acting editor of the QUARTERLY. George L. Warner, M. D., has been appointed acting director of Marcy State Hospital.

Dr. Bigelow, who has been editor of THE PSYCHIATRIC QUARTERLY since the death of the late Richard H. Hutchings in October 1947, and senior director of Marcy since 1945, was appointed acting commissioner to succeed Frederick MacCurdy, M. D., who resigned to become medical consultant to the New York State Citizen's Committee of One Hundred for Children and Youth. Brief biographical notes on Dr. Bigelow are included in the section, "Contributors to This Issue," in this number of THE QUARTERLY.

Dr. Whitehead will assume the duties of editor, effective with the July 1950 number of THE PSYCHIATRIC QUARTERLY and Part 1 of the 1950 PSYCHIATRIC QUARTERLY SUPPLEMENT. He is senior associate editor of THE QUARTERLY and has been a member of the editorial board since 1940. Born in Lynn, Mass., in 1905, he was educated in the Lynn and Fitchburg, Mass., public schools, then attended Cornell University where he received his A. B. degree in 1926, and his master's degree in 1928. From 1926 to 1928 he was, first, assistant, then instructor, in anatomy at Cornell. He received his medical degree from the Cornell University Medical School in 1931. After leaving medical school, Dr. Whitehead served for a short time at Utica (N. Y.) State Hospital, then served an internship at Bellevue, where he remained for two years. He entered state hospital service permanently in 1934 and, except for military service, has remained with the state hospital system ever since. He was in the army from 1941 to 1946, serving for most of that period as a lieutenant-colonel, chiefly at Lovell General Hospital, Fort Devens, Mass. He was discharged with the rank of colonel.

Dr. Whitehead was promoted, through the various grades, to assistant director (clinical) at Utica in 1946, transferring that same year to the position of assistant director (clinical) at Brooklyn. He is the author of a number of scientific papers on mental hygiene and psychiatric subjects, and

is assistant professor of clinical psychiatry at the College of Medicine of the State University Medical Center at New York (formerly the Long Island College of Medicine). He is a diplomate in psychiatry of the American Board of Psychiatry and Neurology. Dr. Whitehead is married and has one son.

JERVIS APPOINTED AS ASSOCIATE EDITOR OF QUARTERLY

George A. Jervis, M. D., director of laboratories of Letchworth Village, N. Y., has been appointed associate editor of THE PSYCHIATRIC QUARTERLY, effective with the present issue. He was named by Dr. Bigelow, the editor, shortly before the appointment of Dr. Whitehead as acting editor. THE QUARTERLY has been without a pathologist on the editorial board since the death of George C. Bower, M. D., of Marcy, N. Y., in December 1947.

Dr. Jervis was born and educated in Europe. He has been connected with the New York State Department of Mental Hygiene since 1934, serving at the New York State Psychiatric Institute before his present appointment at Letchworth Village. He is the author of more than 50 papers dealing with neuropathology and child neurology. He is a diplomate of the American Board of Psychiatry and Neurology in both psychiatry and neurology; his professional societies include the Association of Neuropathologists, the Academy of Neurology, the American Psychiatric Association, the Society of Experimental Biology and Medicine, and the American Association on Mental Deficiency.

Dr. Jervis served as an air force neuropsychiatrist from 1942 to 1946. He is married and has one child.

MAC CURDY BECOMES YOUTH COMMITTEE CONSULTANT

Frederick MacCurdy, M. D., New York State commissioner of mental hygiene since 1943, resigned that position on April 1, 1950, to become medical consultant to the New York State Citizen's Committee of One Hundred for Children and Youth. The appointment was made by Governor Dewey.

Dr. MacCurdy, in a farewell statement, commended the personnel of the department for "splendid co-operation and loyalty." *The New York Times* paid him editorial tribute.

Dr. MacCurdy was professor of hospital administration at Columbia University and director of the Vanderbilt Clinic, New York City, when he was appointed commissioner of mental hygiene. A graduate of the University of Washington and of the College of Physicians and Surgeons, Columbia University, he was in private practice before World War I, in which he

served with the United States Army Medical Corps overseas. On return to New York, he took an active part in planning, and later in administering, the new Columbia-Presbyterian Medical Center. He was one of the original members of the joint administrative board of the center, apart from his duties of teaching administration at Columbia.

WALTER M. PAMPHILON, M. D., DIES AT 52

Walter M. Pamphilon, M. D., assistant commissioner of the New York State Department of Mental Hygiene since 1945, died after a long illness at his home in Jackson Heights, N. Y., on March 29, 1950 at the age of 52. Head of the department's New York City office, Dr. Pamphilon was a veteran of 26 years service with the department.

Born in Toronto, he was graduated from the University of Toronto's medical school in 1922, after having interrupted his studies in 1918 to join the British navy and serve as surgeon sub-lieutenant in the Dover patrol and the Grand Fleet. Following his graduation from medical school, he served a rotating internship at Buffalo City Hospital, then joined the New York State service at Buffalo State Hospital. He left that hospital in 1928 for service with the Veterans Administration but returned the following year. He was assistant director of Willard State Hospital and acting medical inspector when he was appointed assistant commissioner. During World War II, he was on the Seneca County War Council and was in charge of the county's emergency medical services.

Dr. Pamphilon leaves his widow, the former Marguerite McGovern of Buffalo, and a son, Walter.

ADOLF MEYER, M. D., DIES IN BALTIMORE AT 83

Adolf Meyer, M. D., founder of the psychobiologic school of human behavior, professor emeritus of psychiatry at the Johns Hopkins University Medical School, and former director of the Henry Phipps Psychiatric Clinic, the Johns Hopkins Hospital, died at his home in Baltimore on March 17, 1950 at the age of 83. He had been ill for nearly two years.

Dr. Meyer, born in 1866 in Switzerland, obtained his medical education in that country, passed his examination for practice in 1890, and did postgraduate study at different times during the next 12 years at Paris, London, Edinburgh, Zürich, Vienna and Berlin. He came to the United States in 1892, where he studied, taught and practised in Illinois and Massachusetts before becoming pathologist of what is now the New York State Psychiatric Institute—then situated on Ward's Island—in 1902. He remained there until 1910, serving also as professor of psychiatry at Cornell University Medical School. He left in that year to become professor

of psychiatry at Johns Hopkins and director of the Phipps clinic, positions he held until his voluntary retirement in 1941 after having served four years beyond the customary retirement age.

Dr. Meyer's concept of psychobiology is generally credited with having had an influence on American psychiatry second only to that of Freud. It is a "genetic-dynamic" concept which gave rise not only to a school of psychiatric thought and to characteristic methods of indoctrination; but its principal tenet, that of consideration of the whole man—of man's behavior and reactions as reflecting a fully-integrated organism rather than a dichotomy of psyche and soma—may be considered basic to almost all modern American psychiatric theory and practice.

Dr. Meyer was the recipient of a wide variety of academic and professional honors. Zürich conferred its M. D. in 1892, and he held honorary degrees from Glasgow, Clark, Yale and Harvard. He was past president of the American Psychiatric Association, the American Neurological Association and the American Psychopathological Association, and was a member or honorary member of many other professional groups, both in the United States and abroad. He was president of the International Committee for Mental Hygiene and honorary president of the National Committee for Mental Hygiene. He had been Salmon memorial lecturer, Maudsley lecturer, and guest lecturer at the Academy of Neurology and Psychiatry, Kharkow.

When Yale's honorary degree of Sc.D. was awarded to him in 1934, President James Rowland Angell of that university referred to Dr. Meyer as "the beloved physician of the ailing mind." He was frequently called "the beloved Adolf Meyer" in his later years. Dr. Meyer was the author of a large number of professional papers on psychiatry, neurology, pathology, mental hygiene and allied subjects. He continued his extensive contributions to the scientific literature through his retirement.

Dr. Meyer married May Potter Brooks of Newburgh, N. Y., in 1902. She survives him, as does a daughter.

29TH CITY TO EMPLOY STRAY ANIMALS FOR EXPERIMENTS

Buffalo, N. Y., has become the twenty-ninth American city to turn unclaimed and unwanted stray dogs and cats over to schools of medicine and other medical institutions for experimentation, according to announcement of the National Society for Medical Research. Omaha, Cleveland and Baltimore are other major cities to have taken similar action recently. Under the new Buffalo ordinance, the S. P. C. A.—which picks up stray dogs and cats under contract with the city, tries to find homes for them, and then turns the unwanted over to the city for destruction—will turn over a proportion instead to the University of Buffalo School of Medicine and other medical institutions.

HUTCHINGS MEMORIAL AWARD STILL OPEN

The special memorial award of $100 to be given in memory of the late Richard H. Hutchings, M. D., former editor of this QUARTERLY and former superintendent of Utica State Hospital, for an outstanding contribution to psychiatry from the public mental institution field, is still open to competition. The award is offered by an anonymous donor through C. Charles Burlingame, M. D., psychiatrist-in-chief of the Institute of Living, Hartford, Conn., and a member of the memorial committee set up to sponsor a series of annual lectures in Dr. Hutchings' honor.

The award is without distinction as to type of professional achievement and may be made by the committee at a time within its discretion. Scientific articles, reports or nominations for the award may be sent to Harry A. Steckel, M. D., chairman of the memorial committee, or to Newton Bigelow, M. D., acting commissioner of the New York State Department of Mental Hygiene, who is the committee's secretary-treasurer.

ALFRED KORZYBSKI IS DEAD AT AGE OF 70

Alfred Korzybski, founder of the "non-Aristotelian" psychological and philosophical discipline of general semantics, known throughout the world as a scientific worker, writer and speaker, died on March 1, 1950 at Sharon, Conn., at the age of 70, after having been stricken with coronary thrombosis the previous day at his nearby home.

Mr. Korzybski, born in Poland, inherited the title "count," but dropped it when, after service as an intelligence officer in the Imperial Russian Army in World War I and a mission to the United States as an artillery expert, he decided—after the Russian Revolution—to remain in this country. His scientific work was initiated in the United States and attracted international attention in 1933 with the publication of his major work, *Science and Sanity: an Introduction to Non-Aristotelian Systems and General Semantics.* In this book, he set forth his concepts of the application of scientific method to the affairs of daily life, particularly those connected with problems of communication.

The principles of general semantics have attracted wide attention among psychiatrists, including Douglas M. Kelley, who used them in training American troops in England for the D-day landings in Normandy. Others who became interested and served as honorary trustees of the Institute of General Semantics, which Mr. Korzybski founded, were: the late Drs. A. A. Brill and Adolf Meyer; and Dr. Nolan D. C. Lewis. Dr. Hervey Cleckley based an interpretation of the psychopathic personality on the principles of general semantics. The general semantic methodology also was used in actual treatment of some cases of wartime breakdowns, and it has been adapted or modified by many psychiatrists for use in or better understanding of, various types of therapies.

Mr. Korzybski's interest in mental disorder was influenced by his study of mental patients under William Alanson White at St. Elizabeths in Washington in 1925 and 1926. He believed that language in which words, structure and usages, as interpreted by the user, did not correspond to verifiable facts, played an important part in mental disease; and he attacked the problem from this direction. While there has been no general psychiatric agreement that faulty communication and the conscious false concepts arising from it are at the basis of mental derangement, there has been general recognition that these factors play important parts in the disease process; and much therapeutic effort, particularly in group psychotherapy, has been expended in reconditioning efforts in the language field. The Korzybski concepts have also been used extensively in intergroup relations programs and in movements to combat race and group prejudice.

Mr. Korzybski was married in 1919 to Mira Edgerly, the portrait painter, who survives him.

INTERNATIONAL CONGRESS ANNOUNCES PROGRAM

The International Congress of Psychiatry, now representing 41 countries, has announced its program for the meetings to be held in Paris September 18 to 27, 1950. Six major matters of discussion are announced. They are: Section 1: "Psychopathology of Delusions," Section 2: "The Application of Mental Tests to Clinical Psychiatry," Section 3: "Cerebral Anatomy and Physiology in the Light of Lobotomies and Topectomies," Section 4: "Indication of Shock-therapy Methods," Section 5: "The Evolution and Present Trends of Psychoanalysis," and Section 6: "Genetics and Eugenics."

Franz Alexander of Chicago will preside over Section 5 and is also a speaker for that section. Other American speakers will be. David Rapaport, Stockbridge, Mass.; Walter Freeman, Washington, D. C.; L. Meduna, Chicago, Ill.; Raymond de Saussure, New York, N. Y.; Manfred Sakel, New York, N. Y.; and Franz Kallmann, Psychiatric Institute, New York, N. Y. The program for Section 7 on child psychiatry has not yet been announced.

Symposia of small groups are projected with six topics tentatively outlined.

The plenary sessions will be held at the Sorbonne and "simultaneous interpretation" will be available. Debates will be reported in English and French. Exhibits will include one on psychopathological art, one on the history and progress of psychiatry, and one on psychiatric books and magazines.

FILMS ON INTERVIEWING AVAILABLE

The Department of Medicine and Surgery of the Veterans Administration announces a series of seven motion pictures to be used for instruction and discussion on the subject of interviewing the psychiatric patient. Three of the films, produced under the technical direction of Dr. Florence Powdermaker and Dr. Jacob Finesinger, are ready for distribution to medical schools, hospitals and other teaching institutions. The films may be borrowed for five-day periods without cost—except for transportation charges—when requests do not conflict with Veterans Administration needs.

Requests may be directed to: Chief, Medical Illustration Division, Department of Medicine and Surgery, Veterans Administration, Washington 25, D. C.

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NEW BOOKLETS FOR WORKERS WITH YOUNG PEOPLE

Science Research Associates announces publication, beginning in September, of a new monthly series of booklets interpreting the problems of young people to adults who work with them. They are similar in format to the present Life Adjustment Series which the company will continue to publish for adolescent readers. The new series is designed for teachers, councilors and parents. Each booklet will be 48 pages, illustrated, treating a "major problem." Dr. William C. Menninger of the Menninger Foundation, Dr. O. Spurgeon English and other widely-known authorities are listed as authors.

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GENERAL SEMANTICS PROGRAM REVISED

Because of the death of Alfred Korzybski, a revision of the program for the seventh summer seminar-workshop in general semantics has been announced by the Institute of General Semantics, Lakeville, Conn. The seminar, from August 14 to September 5, will take place in Great Barrington, Mass., with Dr. J. S. A. Bois, past president of the Canadian Psychological Association, substituting for Mr. Korzybski in conducting the basic training seminar. Daniel Wheeler, M. D., Springfield, Mass., psychiatrist, will be one of the workshop lecturers.

THE AMERICAN JOURNAL OF MENTAL DEFICIENCY

RICHARD H. HUNGERFORD, *Editor*

The April 1950 issue of the American Journal of Mental Deficiency includes

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